

11932

CERTIFICATE OF DEATH

11928

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany Co. - Jefferson</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Allegany</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland no all her life</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cumberland</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Allegany Infirmary</i>				d. STREET ADDRESS <i>Maryland</i>			
3. NAME OF DECEASED (Type or print) First <i>Margaret</i> Middle <i>Abbott</i> Last <i>Abbott</i>				4. DATE OF DEATH Month <i>11</i> Day <i>28</i> Year <i>1958</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 25, 1871</i>	9. AGE (In years last birthday) <i>87</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>✓</i>		11. BIRTHPLACE (State or foreign country) <i>Allegany Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Sloan</i>				14. MOTHER'S MAIDEN NAME <i>Margaret Holmes</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT Address <i>Mrs. Frances Yernall, 454 Fayette St.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Sclerosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial insufficiency</i> (c) <i>General arteriosclerosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>Sudden</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Senile deterioration</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Nov. 25, 1958</i> to <i>Nov. 28, 1958</i> that I last saw the deceased alive on <i>Nov. 28, 1958</i> , and that death occurred at <i>7:45 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>James E. McLean</i> M.D.		ADDRESS (Street, city or town, state) <i>49 Greencroft</i>		DATE SIGNED <i>11/29/58</i>			
PHYSICIAN'S NAME (Type) <i>Dr. James E. McLean</i>		Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Dec. 1, 1958</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Oak Hill Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Lonaconing, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Charles L. George, Cumberland, Md.</i>				24a. REC'D BY REGISTRAR <i>DEC 3 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>	

12003 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Broad Run		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 4 Weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Broad Run		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Great Meadows Farms			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LAURA Middle LYDE Last ADAMS			4. DATE OF DEATH Month November Day 7 Year 19 58		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1879		9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Tazewell, Virginia	
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME John Montgomery Thompson		
14. MOTHER'S MAIDEN NAME Eliza Higginbotham			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. None			17. INFORMANT Great Meadows Farms Address Mrs. Nelson Hutchins Frostburg, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio-Sclerotic Cardio- 422.1 DUE TO vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } DUE TO (b) 4-5 yrs. (c) 4-5 yrs.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from 10-8 , 19 58 , to 11-7 , 19 58 , that I last saw the deceased alive on 11-7 , 19 58 , and that death occurred at 12:15 P. M, from the causes and on the date stated above.					
ACTUAL SIGNATURE H. C. Diehl		M.D. Frostburg, Md		DATE SIGNED 11/8/58	
PHYSICIAN'S NAME (Type) H. C. Diehl M.D. 39 West Main Street, Frostburg, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/10/58		22c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery	
22d. LOCATION (City, town, or county) (State) Broad Run, Virginia					
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			ADDRESS		24a. REC'D BY REGISTRAR NOV 12 '58
24b. REGISTRAR'S SIGNATURE Arthur L. Kraw					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

Name of Deceased		Sex		Age		Date of Birth		Place of Birth	
Name of Informant		Relationship		Occupation		Residence		City and State	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death	
Date of Death		Time of Death		Place of Death		Physician		Hospital	
Signature of Informant		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner	
Date of Report		Time of Report		Place of Report		City and State		County	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11933

CERTIFICATE OF DEATH

11930

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hosp</u>				d. STREET ADDRESS <u>215 Decatur St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Sister</u> Middle <u>Louise</u> Last <u>Anderson</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>26.</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 14 1882</u>	
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Reg. Nurse</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Sacred Heart Hosp</u>			
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Zachary T. Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Theresa Hill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>				16. SOCIAL SECURITY NO. <u></u>			
17. INFORMANT <u>Sacred Heart Hosp</u>				Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u></u> Month <u></u> Day <u></u> Year <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Nov 24</u> , 19 <u>58</u> , to <u>Nov 26</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 26</u> , 19 <u>58</u> , and that death occurred at <u>1:45</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leo V. Key Jr.</u>				ADDRESS (Street, city or town, state) <u>456 N. Centre St.</u>			
DATE SIGNED <u></u>							
PHYSICIAN'S NAME (Type) <u>Dr. Leo V. Key Jr.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/28/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cem.</u>		22d. LOCATION (City, town, or county) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb Md</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR	
DATE <u>NOV 28 '58</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Frank</u>			

STATE DEPARTMENT OF HEALTH - BIRMINGHAM, ALA.

CERTIFICATE OF DEATH

WILLIAMS

11030

11030

11934

CERTIFICATE OF DEATH

Reg. Dist. No. 11931

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 65 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 106 Mullin Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Naomi Middle W. Last Beaver				4. DATE OF DEATH Month Nov. Day 8 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 17, 1876	9. AGE (In years lost birthday) yrs. 82	IF UNDER 1 YEAR Months 82	IF UNDER 24 HRS. Days 82	Hours 82
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Bedford County, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith				14. MOTHER'S MAIDEN NAME Eliza Barnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Mrs. Violet Catanese, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial, chronic, senile 422.2 DUE TO degenerative Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) degenerative (c) degenerative							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 49 Greene St.	(County)	(State)		
21. I certify that I attended the deceased from 1953 , 19____, to 11/8/58 , 19____, that I last saw the deceased alive on 11/8/58 , 19____, and that death occurred at 11:15 M. from the causes and on the date stated above.							DATE SIGNED Nov. 10, 1958
ACTUAL SIGNATURE Robert Mathews		M.D. 49 Greene St.		ADDRESS (Street, city or town, state) Cumberland, Maryland			
PHYSICIAN'S NAME (Type) Dr. L. B. Mathews							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 11, 1958	22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11932

11935

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ACCIDENT 11X-2	
c. LENGTH OF STAY IN 1b 13 HOURS		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SIDNEY Middle M. Last BEITZEL		4. DATE OF DEATH Month NOVEMBER Day 26 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 13,
9. AGE (In years last birthday) 38 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOBSEWORIT		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME SILAS BITTINGER		14. MOTHER'S MAIDEN NAME MAUDE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Ventricular Failure 410X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Mitral Stenosis - Myocardial fibrosis DUE TO (c) ??		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterial Embolus - Multiple (L. Iliac - Rt. Popliteal)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov. 26, 1958 , to Nov 26, 1958 , that I last saw the deceased alive on Nov 26, 1958 , and that death occurred at 4:15 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Samuel Jacobson M.D.		ADDRESS (Street, city or town, state) 50 PERSHING ST. DATE SIGNED 11/28/58	
PHYSICIAN'S NAME (Type) DR. SAMUEL M. JACOBSON		CUMBERLAND MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 11/29/58	22c. NAME OF CEMETERY OR CREMATORY ACCIDENT	22d. LOCATION (City, town, or county) (State) ACCIDENT, GARRETT CO MD
23. FUNERAL DIRECTOR'S SIGNATURE Ben J. Newman, Grantsville, Md.		24a. REC'D BY REGISTRAR DATE DEC 3 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kiser			

1183

DEPARTMENT OF HEALTH - BALTIMORE, MD.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
MARY		F		40		JAN 1 1880		BALTIMORE, MD.	
MARRIED		YES		DATE		PLACE		BY	
JAN 1 1900		BALTIMORE, MD.		J. J. JONES		J. J. JONES		J. J. JONES	
OCCUPATION		HUSBAND		DATE		PLACE		BY	
JAN 1 1900		BALTIMORE, MD.		J. J. JONES		J. J. JONES		J. J. JONES	
CAUSE OF DEATH		DISEASE		DATE		PLACE		BY	
JAN 1 1900		BALTIMORE, MD.		J. J. JONES		J. J. JONES		J. J. JONES	
PLACE OF DEATH		HOSPITAL		DATE		PLACE		BY	
JAN 1 1900		BALTIMORE, MD.		J. J. JONES		J. J. JONES		J. J. JONES	
SIGNATURE OF PHYSICIAN		DATE		PLACE		BY		BY	
JAN 1 1900		BALTIMORE, MD.		J. J. JONES		J. J. JONES		J. J. JONES	
SIGNATURE OF REGISTRAR		DATE		PLACE		BY		BY	
JAN 1 1900		BALTIMORE, MD.		J. J. JONES		J. J. JONES		J. J. JONES	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11933

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY 12016 Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corriganville		c. LENGTH OF STAY IN 1b years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Residence		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Corriganville	
3. NAME OF DECEASED (Type or print) HARVEY WEBSTER BOOR		4. DATE OF DEATH Month November Day 11 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 13, 1880
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months 78 Days 11	11. IF UNDER 24 HRS. Hours 11 Min. 58
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Painter & Carpenter	
11. BIRTHPLACE (State or foreign country) Bedford County, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John R Boor		14. MOTHER'S MAIDEN NAME Christiana Sliger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-16-9334	
17. INFORMANT Mrs. Matilda Boor,		Address Corriganville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Coronary Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH Sudden ? </div> </div>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Nov. 13, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF November 14, 1958	22c. NAME OF CEMETERY OR CREMATORY Centerville Meth.	22d. LOCATION (City, town, or county) (State) Centerville, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Funeral Director		24a. REC'D BY REGISTRAR NOV 17 '58	
ADDRESS John J. Hafer, Funeral Director		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1973

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

150127

FOR STATE
HEALTH TEST



150127



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11936 CERTIFICATE OF DEATH

Reg. Dist. No.

11934

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS ARMSTRONG STREET EXTENDED	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle O Last BORROR		4. DATE OF DEATH Month NOVEMBER Day 29 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 12
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auctioneer		11b. KIND OF BUSINESS OR INDUSTRY W.V.A.	
12. BIRTHPLACE (State or foreign country) U.S.A.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME RALEIGH BORROR		15. MOTHER'S MAIDEN NAME HENRIETTA YANKEE	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		17. SOCIAL SECURITY NO. 232-54-4323	
18. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from esophageal varices 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cirrhosis of liver DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 15 months Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9 PM , 1958 , to 11-29 , 1958 , that I last saw the deceased alive on 11-29 , 1958 , and that death occurred at 9:35 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Carlton Brinsfield		ADDRESS (Street, city or town, state) 232 Baltimore Ave	
PHYSICIAN'S NAME (Type) CARLTON BRINSFIELD		DATE SIGNED Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3 Dec. 58	
22c. NAME OF CEMETERY OR CREMATORY Cabin Run		22d. LOCATION (City, town, or county) (State) Keyser, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Allen M. Kofman		ADDRESS Keyser, W. Va.	
24a. REC'D BY REGISTRAR DATE DEC 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11935

11937

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		d. STREET ADDRESS 1 ALLEGANY COUNTY INFIRMARY	
d. NAME OF HOSPITAL (If institutional: Hospital name and address) OR INSTITUTION WARWICK & MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMMA Middle BOWMAN Last BOWMAN		4. DATE OF DEATH Month NOVEMBER Day 3 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 5,
9. AGE (In years lost birthday) 67 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JACOB, BEEGHLEY		14. MOTHER'S MAIDEN NAME CATHRINE SPEICHER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 586X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aneurysm - cholelithotomy DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 2
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Urinary incontinence; inability to walk; poor circulation in legs.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part V of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 31 Oct , 19 58 , to 3 Nov , 19 58 , that I last saw the deceased alive on 3 Nov , 19 58 , and that death occurred at 4:45 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 232 Britton Ave DATE SIGNED ACTUAL SIGNATURE Carlton Brinsfield M.D. Carlton Brinsfield, M.D. PHYSICIAN'S NAME (Type) DOCTOR CARLTON BRINSFIELD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/58	
22c. NAME OF CEMETERY OR CREMATORY Church Of Brethern		22d. LOCATION (City, town, or county) (State) Accident Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montross		24a. REC'D BY REGISTRAR NOV 12 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. House		24c. REGISTRAR'S SIGNATURE Arthur S. House	

12004 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 First Street				d. STREET ADDRESS 21 First St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Nellie Middle Brode Last Brode				4. DATE OF DEATH Month November Day 22 Year 19 58			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 8/9/1889		9. AGE (In years last birthday) 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Examiner (Retired)		10b. KIND OF BUSINESS OR INDUSTRY Shirt Factory		11. BIRTHPLACE (State or foreign country) Consolidation Village		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Lewis				14. MOTHER'S MAIDEN NAME Eleanor Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-01-9642		17. INFORMANT Mr. Benjamin Lewis, 64 McCulloh St.,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO 3-4 yrs. (c) Chronic Myocarditis DUE TO 4-5 yrs.				INTERVAL BETWEEN ONSET AND DEATH 48 hrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Frostburg		(County) (State)	
21. I certify that I attended the deceased from 11-20 , 19 58 , to 11-22 , 19 58 , that I last saw the deceased alive on 11-22 , 19 58 , and that death occurred at 2 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H.C. Diehl				ADDRESS (Street, city or town, state) 39 W. Main St. Frostburg, Md.			
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.				DATE SIGNED 11/24/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-58		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montross				24a. REC'D BY REGISTRAR NOV 26 '58		24b. REGISTRAR'S SIGNATURE Carlton S. Frank	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1138

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1918

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 15, 1918		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Farmer		Natural	
Signature of Physician		Signature of Registrar		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Report		Place of Report		Cause of Report	
Jan 16, 1918		Baltimore		Death	
Signature of Reporter		Signature of Coroner		Signature of Registrar	
[Signature]		[Signature]		[Signature]	

John Doe

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 236 11-21-58 ans

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11937

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna. b. COUNTY Fayette			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cumberland				c. LENGTH OF STAY IN 1b several hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6 miles east of Cumberland, Rt.40				d. STREET ADDRESS Rural Farmington 75x-3			
3. NAME OF DECEASED (Type or print) First HARRY Middle BRYNER Last				4. DATE OF DEATH Month November Day 14 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH Jan. 14, 1933		9. AGE (In years last birthday) 25 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Housing		11. BIRTHPLACE (State or foreign country) Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Okey Bryner				14. MOTHER'S MAIDEN NAME Mamie Tressler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 205 26 8649		17. INFORMANT Gleason Funeral Home Uniontown, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest, Broken neck 825x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Crushed under upset truck. Deceased according to history was driver.					
20c. TIME OF INJURY Hour 4:45 p. m. Nov. 14 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street		20f. (City or town) (County) (State) RD Cumberland, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 14, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1958		22c. NAME OF CEMETERY OR CREMATORY Belle Grove Cemetery		22d. LOCATION (City, town, or county) (State) Ohionyle, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Harold S. Gleason				ADDRESS Uniontown, Pa.		24c. REC'D BY REGISTRAR NOV 17 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BULLMOSE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11887

1. Name of deceased: John J. Smith
2. Age: 45
3. Sex: Male
4. Date of death: Nov. 15, 1921
5. Place of death: Home
6. Cause of death: Heart Disease
7. Manner of death: Natural
8. Signature of Medical Examiner: [Signature]
9. Date of examination: Nov. 16, 1921
10. Location of examination: Home
11. Name of attending physician: Dr. J. B. Jones
12. Name of coroner: John A. Smith
13. Name of registrar: John A. Smith
14. Name of undertaker: John A. Smith
15. Name of funeral home: John A. Smith
16. Name of cemetery: John A. Smith
17. Name of church: John A. Smith
18. Name of place of burial: John A. Smith
19. Name of place of interment: John A. Smith
20. Name of place of cremation: John A. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12018

CERTIFICATE OF DEATH

11939

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 6 Cumberland,		c. LENGTH OF STAY IN 1b X Rt. # 6 Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cresap Drive, Bowling Greene		d. STREET ADDRESS Cresap Drive, Bowling Greene	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LESTER Middle CAMERON Last CAMERON		4. DATE OF DEATH Month November Day 5 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 27, 1918
9. AGE (In years last birthday) 40 yrs.		IF UNDER 1 YEAR Months 40 Days 40 Hours 40 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Quality control clerk		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
11. BIRTHPLACE (State or foreign country) Lonaconing, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Cameron		14. MOTHER'S MAIDEN NAME Willia M. Wiland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes, W. W. 2		16. SOCIAL SECURITY NO. 217-10-5239	
17. INFORMANT Mrs. Sara M. Cameron		Address Rt. # 6 Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease. (c) None		INTERVAL BETWEEN ONSET AND DEATH One day. Six years.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 25, 19 53, to November 5, 19 58, that I last saw the deceased alive on November 5, 19 58, and that death occurred at 12:55 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE James P. Hallinan M.D.		ADDRESS (Street, city or town, state) 140 Bedford St.,	
PHYSICIAN'S NAME (Type) James P. Hallinan M. D.		DATE SIGNED 11-6-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/58	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR DATE NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12005

CERTIFICATE OF DEATH

11938

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		c. LENGTH OF STAY IN 1b 36 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 43			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 111 Green				d. STREET ADDRESS 111 Green		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Campbell Last 4. DATE OF DEATH Month Nov. Day 17 Year 19 58							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 14, 1870	9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Coal mine		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Campbell				14. MOTHER'S MAIDEN NAME Emily Fromhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Aden Campbell-Piedmont, W.Va. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dependence on Not specified as Rheumatic 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 28, 1958 , to Nov. 17, 1958 , that I last saw the deceased alive on Nov. 7, 1958 , and that death occurred at 4:35 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 111 Ash Rd St. Piedmont W.Va DATE SIGNED 11-18-58 ACTUAL SIGNATURE Paul R. Wilson M.D. PHYSICIAN'S NAME (Type) Paul R. Wilson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/58		22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md	
23. FUNERAL DIRECTOR'S SIGNATURE E. J. Boral ADDRESS Westernport, Md.				24a. REC'D BY REGISTRAR DATE NOV 19 58		24b. REGISTRAR'S SIGNATURE Orin E. Kneave	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12006

CERTIFICATE OF DEATH

11940

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eckhart</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Miner's Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edward</u> Middle <u>J.</u> Last <u>Carter</u>				4. DATE OF DEATH Month <u>November</u> Day <u>5th</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 4th, 1887</u>		9. AGE (In years lost birthday) yrs. <u>71</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Conductor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Md. Railway</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levi Carter</u>				14. MOTHER'S MAIDEN NAME <u>Frances Hamill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>712-14-1546</u>		17. INFORMANT Address <u>Mrs. Sarah L. Carter, Eckhart, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>241X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Bronchial Asthma</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>12 mo</u> <u>several years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>Oct 22</u> , 19 <u>58</u> , to <u>Nov 5</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 5</u> , 19 <u>58</u> , and that death occurred at <u>9:45 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Frostburg Md.</u> DATE SIGNED <u>Nov 5 1958</u> ACTUAL SIGNATURE <u>W. O. Mc Lane</u> M.D. <u>W. O. Mc Lane</u> PHYSICIAN'S NAME (Type) <u>W. O. Mc Lane</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-7-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst,</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>			

11040

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SINGLE		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		SIGNATURE OF DECEASED	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11938. CERTIFICATE OF DEATH

11941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10/18/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Christina Last Combs		4. DATE OF DEATH Month November Day 12 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/11/1905
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR: Months 53 Days 53 Hours 53 Min. 53	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Textile worker		12. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	
13. FATHER'S NAME Edward Hanlin		14. MOTHER'S MAIDEN NAME Letta Simmons	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-10-8869	
17. INFORMANT P.O. Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion. DUE TO 174X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocarditis DUE TO Chronic Hepatitis (c) Carcinoma uterus & Metastasis		INTERVAL BETWEEN ONSET AND DEATH 36 hrs. ? 24 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Hepatitis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/18/58 , 19 58 , to 11/12/58 , 19 58 , that I last saw the deceased alive on 11/12/58 , 19 58 , and that death occurred at 12:10A , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/12/58	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BALTIMORE 12 11/1/58	
NAME OF DECEASED [Illegible]	
SEX [Illegible]	
DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]	
OCCUPATION [Illegible]	
MARITAL STATUS [Illegible]	
DATE OF DEATH [Illegible]	
PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]	
MANNER OF DEATH [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF REGISTRAR [Illegible]	
SIGNATURE OF WITNESS [Illegible]	
SIGNATURE OF DECEASED [Illegible]	
SIGNATURE OF NEXT OF KIN [Illegible]	
SIGNATURE OF BURIAL OFFICIAL [Illegible]	
SIGNATURE OF CLERK [Illegible]	

TO TO BE COMPLETED BY THE FUNERAL HOME OR BY THE DECEASED'S NEAREST RELATIVE. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please register the carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HEALTH—BALTIMORE, 18

11939

CERTIFICATE OF DEATH

11942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 8/1/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cumberland	
f. STREET ADDRESS RFD#2, Baltimore Pike		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle Belle Last Cramer		4. DATE OF DEATH Month November Day 2 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/24/1877
9. AGE (In years last birthday) yrs. 81		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11c. BIRTHPLACE (State or foreign country) Pennsylvania, Fulton Co		11d. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME John H. Miller		14. MOTHER'S MAIDEN NAME Elizabeth May	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Chronic myocarditis Cerebral arteriosclerosis Chronic nephritis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/1/56 , 19____, to 11/2/58 , 19____, that I last saw the deceased alive on 11/1/58 , 19____, and that death occurred at 5:40A AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/3/58	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-4-58	
22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR NOV 7 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

James F. Scarpelli

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11940

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 02 Cumberland,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D. O. A. Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First William Middle Donald Last Crosten		4. DATE OF DEATH Month Nov. Day 28 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1958
9. AGE (In years last birthday) 0 yrs.		IF UNDER 1 YEAR Months 1 Days 19	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME William D. Crosten	
14. MOTHER'S MAIDEN NAME Bonnie Lee Bennett		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Wm. D. Crosten 343 Nat. Hwy. Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 7547 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Aortic Stenosis, marked; Congenital DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 Hrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tracheo-bronchitis, mild			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Benedict Skitarelic		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED Nov. 28, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/29/58	22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

MEDICAL CERTIFICATION

2

2060161XV6

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11012

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF CEMETERY		20. SIGNATURE OF INTERMENT		21. SIGNATURE OF RECORDS	
22. SIGNATURE OF VITALS		23. SIGNATURE OF DEATH		24. SIGNATURE OF CERTIFICATE	
25. SIGNATURE OF DEATH		26. SIGNATURE OF DEATH		27. SIGNATURE OF DEATH	
28. SIGNATURE OF DEATH		29. SIGNATURE OF DEATH		30. SIGNATURE OF DEATH	
31. SIGNATURE OF DEATH		32. SIGNATURE OF DEATH		33. SIGNATURE OF DEATH	
34. SIGNATURE OF DEATH		35. SIGNATURE OF DEATH		36. SIGNATURE OF DEATH	
37. SIGNATURE OF DEATH		38. SIGNATURE OF DEATH		39. SIGNATURE OF DEATH	
40. SIGNATURE OF DEATH		41. SIGNATURE OF DEATH		42. SIGNATURE OF DEATH	
43. SIGNATURE OF DEATH		44. SIGNATURE OF DEATH		45. SIGNATURE OF DEATH	
46. SIGNATURE OF DEATH		47. SIGNATURE OF DEATH		48. SIGNATURE OF DEATH	
49. SIGNATURE OF DEATH		50. SIGNATURE OF DEATH		51. SIGNATURE OF DEATH	
52. SIGNATURE OF DEATH		53. SIGNATURE OF DEATH		54. SIGNATURE OF DEATH	
55. SIGNATURE OF DEATH		56. SIGNATURE OF DEATH		57. SIGNATURE OF DEATH	
58. SIGNATURE OF DEATH		59. SIGNATURE OF DEATH		60. SIGNATURE OF DEATH	
61. SIGNATURE OF DEATH		62. SIGNATURE OF DEATH		63. SIGNATURE OF DEATH	
64. SIGNATURE OF DEATH		65. SIGNATURE OF DEATH		66. SIGNATURE OF DEATH	
67. SIGNATURE OF DEATH		68. SIGNATURE OF DEATH		69. SIGNATURE OF DEATH	
70. SIGNATURE OF DEATH		71. SIGNATURE OF DEATH		72. SIGNATURE OF DEATH	
73. SIGNATURE OF DEATH		74. SIGNATURE OF DEATH		75. SIGNATURE OF DEATH	
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100. SIGNATURE OF DEATH		101. SIGNATURE OF DEATH		102. SIGNATURE OF DEATH	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12019

CERTIFICATE OF DEATH

11944

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cresaptown, Maryland</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Cresaptown, Maryland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cresaptown, Maryland</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Patrick</u> Middle <u>Henry</u> Last <u>Cuff</u>		4. DATE OF DEATH Month <u>November</u> Day <u>30</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 17, 1871</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. BIRTHPLACE (State or foreign country) <u>Franklin, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Patrick Henry Cuff</u>		14. MOTHER'S MAIDEN NAME <u>Bridget Riordam</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Dale Broadwater, Cresaptown, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cachexia</u> 140.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>carcinoma of lower lip</u> DUE TO (c) <u>6 weeks</u> 6 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-7-1958</u> to <u>12-30-1958</u> , that I last saw the deceased alive on <u>11-30-1958</u> , and that death occurred at <u>5:30 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>L. Brings</u> M.D. <u>5 Thelma P</u> PHYSICIAN'S NAME (Type) <u>L. Brings, M.D.</u> <u>57 Greene St, Cumberland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 3, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St Ambrose Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cresaptown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George, Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 4 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>			

CERTIFICATE OF DEATH

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11941

CERTIFICATE OF DEATH

11945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u>		d. STREET ADDRESS <u>107 Valley St.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>107 Valley Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Josephine</u> Last <u>Darber</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14, 1883</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William L. Nehring</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Rohman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		17. INFORMANT Address <u>Edmund E. Darber 107 Valley St</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2 years</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-14</u> , 19 <u>58</u> , to <u>11-7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-7</u> , 19 <u>58</u> , and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Ralph W. Ballin</u>		ADDRESS (Street, city or town, state) <u>62 Greene St.</u> DATE SIGNED <u>11-7-58</u>	
PHYSICIAN'S NAME (Type) <u>Ralph W. Ballin</u>		<u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>11/8/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Peter + Paul Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb. Md.</u> ADDRESS		24a. REC'D BY REGISTRAR <u>NOV 10 '58</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneave</u>

CERTIFICATE OF DEATH

1911

FILE NO. 14

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. TIME OF DEATH</p>		<p>10. SIGNATURE OF PHYSICIAN</p>	
<p>11. SIGNATURE OF REGISTRAR</p>		<p>12. SIGNATURE OF WITNESS</p>	



TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11942

CERTIFICATE OF DEATH

11946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna. b. COUNTY Allegheny	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle CARROLL Last DARKEY		4. DATE OF DEATH Month NOVEMBER Day 5 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 10, 1892
9. AGE (In years lost birthday) 66 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil engineer		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) OLDTOWN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME FRANCIS DARKEY		14. MOTHER'S MAIDEN NAME LANEY M. SHRYOCK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 206-07-6792	
17. INFORMANT WARWICK & MEMORIAL AVE., MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of sigmoid 153.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinomatosis of abdominal DUE TO (c) viscera			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> In Aug '58 Abdomino-perineal resection			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 15, 1958 to 11-5- , 19 58 , that I last saw the deceased alive on 11-4- , 19 58 , and that death occurred at 2:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland Md DATE SIGNED 11-5-58			
ACTUAL SIGNATURE W. F. Williams M.D.			
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/7/58	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE Charles L. George	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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11943
CERTIFICATE OF DEATH

11947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 622 BROOKFIELD AVENUE	
3. NAME OF DECEASED (Type or print) First Middle Last GEORGE P. DAVIS		4. DATE OF DEATH Month Day Year NOVEMBER 6 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 19,
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Orchardist		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS P. DAVIS		14. MOTHER'S MAIDEN NAME MARY E. HERPICH	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT WARWICK & MEMORIAL AVE., MEMORIAL HOSPITAL - CUMBERLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic Cardio vascular DUE TO (c) renal disease with Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 1 year +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 3 , 19 58 , to Nov 6 , 19 58 , that I last saw the deceased alive on Nov 5 , 19 58 , and that death occurred at 3:55 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Wylie M Faw Jr.		ADDRESS (Street, city or town, state) Cumberland md	
DATE SIGNED Nov 7, 58			
PHYSICIAN'S NAME (Type) DR. GEORGE SYMONS WYLIE M. FAW JR.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/58	
22c. NAME OF CEMETERY OR CREMATORY mt. labor Cem.		22d. LOCATION (City, town, or county) (State) Spring Gap md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc		ADDRESS Cumb. Md	
24a. REC'D BY REGISTRAR NOV 10 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 19

PLACE OF BIRTH MARYLAND		SEX MALE	
DATE OF BIRTH MAY 15 1913		AGE 46 YEARS	
PLACE OF DEATH BALTIMORE		DATE OF DEATH MAY 15 1959	
TIME OF DEATH 10:00 AM		CAUSE OF DEATH HEART DISEASE	
PLACE OF INTERMENT GREENMOUNT CEMETERY		DATE OF INTERMENT MAY 16 1959	
NAME OF DECEASED THOMAS S. DAVIS		NAME OF NEXT OF KIN MARY E. DAVIS	
ADDRESS OF DECEASED 1234 BALTIMORE ST. BALTIMORE, MD.		ADDRESS OF NEXT OF KIN 5678 BALTIMORE ST. BALTIMORE, MD.	
OCCUPATION ENGINEER		EDUCATION HIGH SCHOOL	
MARITAL STATUS MARRIED		NUMBER OF CHILDREN 3	
SIGNATURE OF DECEASED THOMAS S. DAVIS		SIGNATURE OF NEXT OF KIN MARY E. DAVIS	
SIGNATURE OF PHYSICIAN DR. J. H. SMITH		SIGNATURE OF CORONER J. H. SMITH	
SIGNATURE OF REGISTRAR J. H. SMITH		SIGNATURE OF CLERK J. H. SMITH	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

11944

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SABRED HEART HOSPITAL				d. STREET ADDRESS 1 347 FREDERICK ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILBERT Middle DAVIS Last DAVIS				4. DATE OF DEATH Month NOV. Day 29, Year 19 58			
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1893	
9. AGE (In years last birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROADER --RETIRED		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM DAVIS (DECEASED)				14. MOTHER'S MAIDEN NAME SUSAN BAKER (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 705 10 4955		17. INFORMANT PATIENTS CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C.V. Renal Disease DUE TO 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6 months							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 25 to Mar 29, 1958 and that death occurred at 12:20 A.M. from the causes and on the date stated above.							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE B. M. Schindler		ADDRESS (Street, city or town, state) 43 GREENE ST., CUMBERLAND, MD.					
PHYSICIAN'S NAME (Type) BLANE M. SCHINDLER, M.D.		DATE SIGNED 4/3/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 2, 1958		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE DEC 2 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6236 12-1-58 et

11949

12020

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke		c. LENGTH OF STAY IN 1b 65 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Luke			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 315 Pratt				d. STREET ADDRESS 315 Pratt		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Newton Last Dawson				4. DATE OF DEATH Month Nov. Day 22 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1887 April 10, 1958	
9. AGE (In years last birthday) 71		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Evaporator Enigneer		11. BIRTHPLACE (State or foreign country) Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Newton Dawson				14. MOTHER'S MAIDEN NAME Sarah Hart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) W.W. 1 217-051135		17. INFORMANT Address Mrs. Lista B. Dawson-Luke, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) carcinoma of Pancreas. 157x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 6mo						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from Oct 10 , 19 58 , to Nov 22 , 19 58 at I last saw the deceased alive on Nov 22 , 19 58 , and that death occurred at 11pm , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE James H. Wolverton Sr M.D. Piedmont W Va PHYSICIAN'S NAME (Type) James H Wolverton Sr							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/25/58		22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Es. Boral ADDRESS Westernport, Md.				24a. REC'D BY REGISTRAR DATE NOV 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11951

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission). a. STATE <u>West Virginia</u> b. COUNTY <u>Morgan</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Luke</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Morgantown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>3068 Separation Station</u>	
3. NAME OF DECEASED (Type or print) <u>Richard</u> First <u>Fairfax</u> Middle <u>Dewitt</u> Last		4. DATE OF DEATH <u>Nov</u> Month <u>10</u> Day <u>1958</u> Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 29 1926</u>
9. AGE (In years last birthday) <u>32</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>	
11. BIRTHPLACE (State or foreign country) <u>W. Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Frank Dewitt</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elliott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give unit or dates of service) <u>World War II</u>		16. SOCIAL SECURITY NO. <u>236-32-6632</u>	
17. INFORMANT <u>WOMcLane</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> DUE TO (b) <u>Lacerated Brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Sudden</u> <u>Sudden</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Scaffold Brake & Fell 50 feet to ground.</u>	
20c. TIME OF INJURY <u>11:15</u> Hour <u>a. m.</u> Month, Day, Year <u>Nov 10 1958</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Factory</u>	20f. (City or town) <u>Luke Allegany Md</u> (County) <u>Morgan</u> (State) <u>MD</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>WOMcLane</u>		DATE SIGNED <u>Nov 10 1958</u>	
EXAMINER'S NAME (Type) <u>WOMcLane MD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>11/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>Morgantown - W. Va</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>El. Boul - Westport, Md</u>		24a. REC'D BY REGISTRAR <u>Nov 13 1958</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thacker</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11945

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 20 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND				d. STREET ADDRESS 1 700 SYLVIAN AVENUE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First GEORGE Middle RAYMOND Last DUCKWORTH		4. DATE OF DEATH Month NOVEMBER Day 15 Year 19 58			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 14, 1876	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 02 Days 02 Hours 02 Min. 02
10a. USUAL OCCUPATION (Give kind of work done during last working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) BLOOMINGTON, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME BUCKWORTH, NELSON			14. MOTHER'S MAIDEN NAME YOUNKER, MARY		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) None		17. INFORMANT Duckworth Address (Son) Charles, 3 Federal St., Frostburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Occlusion 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from 26 Oct., 19 58 , to 15 Nov., 19 58 , that I last saw the deceased alive on 15 Oct., 19 58 , and that death occurred at 4:15 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 So. Centre St., Cumberland Md., 16801 DATE SIGNED 58					
ACTUAL SIGNATURE James E. Stegmaier		M.D. 122 So. Centre St., Cumberland Md., 16801			
PHYSICIAN'S NAME (Type) DR. JAMES STEGMAIER					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-18-58		22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	
22d. LOCATION (City, town, or county) Frostburg, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Berndt H. Montecant		ADDRESS Hafer Funeral Home		24a. REC'D BY REGISTRAR NOV 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11953

11946

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Linda Middle M Last Eagan		4. DATE OF DEATH Month Nov Day 19 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/1/57
9. AGE (In years last birthday) 1 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Eagan		14. MOTHER'S MAIDEN NAME Hilda Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Pt. Chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7545 Congenital malformation of the heart (septal defects) DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) acute respiratory infection			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July , 19 58 , to 11/19 , 19 58 , that I last saw the deceased alive on 11/19 , 19 58 , and that death occurred at 11:40 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 55 Greene Street DATE SIGNED Elizabeth Briggs			
ACTUAL SIGNATURE Elizabeth Briggs M.D.			
PHYSICIAN'S NAME (Type) Dr. E. Briggs			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/21/58	
22c. NAME OF CEMETERY OR CREMATORY Belvedere Cemetery		22d. LOCATION (City, town, or county) (State) Midland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR NOV 24 '58	
ADDRESS Lonaconing, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

11938

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEATH

PLACE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11947

CERTIFICATE OF DEATH

11954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland md</u>	
c. LENGTH OF STAY IN lb <u>Life</u>		d. STREET ADDRESS <u>854 Camden Ave</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>— 854 Camden Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Frederic</u> Middle <u>William</u> Last <u>Eiler</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>29</u> Year <u>1958</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>mar 24 1898</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR: Months <u>60</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Automobile Dealer (Self)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Norfolk Va.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederic Wolfe Eiler</u>		14. MOTHER'S MAIDEN NAME <u>Isabelle Garrison</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>1st World War</u>		16. SOCIAL SECURITY NO. <u>124 World War</u>	
17. INFORMANT <u>Mary W Eiler wife - Same</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Mon</u> , 1946, to <u>29 Nov</u> , 1958, that I last saw the deceased alive on <u>29 Nov</u> , 1958, and that death occurred at <u>4 P</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>F. B. Whitworth</u> M.D.		ADDRESS (Street, city or town, state) <u>123 Balford St Cumberland Md</u> DATE SIGNED <u>29 Nov 58</u>	
PHYSICIAN'S NAME (Type) <u>F. B. Whitworth</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12/2/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumb Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 3 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Curtis L. Hanna</u>	

CERTIFICATE OF DEATH

Name of Deceased <i>William F. Whitworth</i>		Date of Birth <i>March 1, 1878</i>	
Sex <i>Male</i>		Race <i>White</i>	
Marital Status <i>Married</i>		Occupation <i>Retired</i>	
Cause of Death <i>Heart Failure</i>		Date of Death <i>March 1, 1948</i>	
Place of Death <i>Home</i>		Signature of Physician <i>Dr. J. B. Whitworth</i>	
Signature of Informant <i>W. F. Whitworth</i>		Signature of Registrar <i>W. F. Whitworth</i>	
Address <i>1234 Main St.</i>		City <i>Baltimore</i>	
State <i>Md.</i>		County <i>Harford</i>	
Date of Report <i>March 1, 1948</i>		Signature of Reporter <i>W. F. Whitworth</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11948

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY Preston	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 HRS. 35 MINS.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROWLESBURG		85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL- WARWICK AND MEMORIAL AVE.		d. STREET ADDRESS Oak Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ALBERT Middle Last ELIASON		4. DATE OF DEATH Month NOVEMBER Day 10 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 22, 1877
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired B&O Engineer		10b. KIND OF BUSINESS OR INDUSTRY B&O R R Co	
11. BIRTHPLACE (State or foreign country) Fellowsville, W.Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Joshua Eliason		14. MOTHER'S MAIDEN NAME Kathrine Goff	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Dis. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 16 Hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-9- , 19 58 , to 11-10- , 19 58 , that I last saw the deceased alive on 11-9- , 19 58 , and that death occurred at 12:45 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE W. J. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland, Md.	
PHYSICIAN'S NAME (Type) DR. W. F. WILLIAMS		DATE SIGNED 11-10-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial		22b. DATE THEREOF 11/12/58	
22c. NAME OF CEMETERY OR CREMATORY Aurora Cemetery		22d. LOCATION (City, town, or county) (State) Aurora, West Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE Fike & Watson		ADDRESS Terra Alta, W.Va.	
24a. REC'D BY REGISTRAR NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12007

CERTIFICATE OF DEATH

11950

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg			c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Mt. Savage		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) KARL E. EWALD				4. DATE OF DEATH Month Nov. Day 23, Year 19 58			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-1-1882	
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired yardmaster		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Ewald				14. MOTHER'S MAIDEN NAME Margaret Henckel			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Agnes Ewald, Mt. Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with Cardiac Failure 1 month DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 o. m. 50 p. m. 23 Month, Day, Year				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Job	
20f. (City or town) Nov. 23				20g. (County) Allegany		20h. (State) MD	
21. I certify that I attended the deceased from July 50 to Nov. 23 , 19 58 , that I last saw the deceased alive on Nov. 23 , 19 58 , and that death occurred at 9:30 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE John B. Davis				DATE SIGNED Broadway			
PHYSICIAN'S NAME (Type) John B. Davis, M. D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-26-58		22c. NAME OF CEMETERY OR CREMATORY St. George Episcopal		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS Frostburg, Md.		24a. REC'D BY REGISTRAR NOV 28 58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

CERTIFICATE OF DEATH

12000

12000

12000

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11956

11049
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 64 days					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First George Middle W. Last Fansler				4. DATE OF DEATH Month Nov. Day 13 Year 1958					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/26/79			
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 26 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Blacksmith				10b. KIND OF BUSINESS OR INDUSTRY Balto & Ohio RR.		11. BIRTHPLACE (State or foreign country) West Virginia			
12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME John Fansler				14. MOTHER'S MAIDEN NAME Alice Gibson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 705-05-4667		17. INFORMANT Chart Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cerebral Vascular Disease DUE TO 442x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO 3 weeks (c)								INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. 0 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from July 13, 1945 to Nov. 13, 1958 that I last saw the deceased alive on Nov. 13, 1958 and that death occurred at 12:45 P.M. from the causes and on the date stated above.									
ACTUAL SIGNATURE B. M. Schindler M.D.				ADDRESS (Street, city or town, state) 43 Greene Street DATE SIGNED 11/13/58					
PHYSICIAN'S NAME (Type) Dr. B.M. Schindler				43 Greene Street					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 16 1958		22c. NAME OF CEMETERY OR CREMATORY Maplewood Cemetery		22d. LOCATION (City, town, or county) (State) Elkins, W.Va.			
23. FUNERAL DIRECTOR'S SIGNATURE William H. Knight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '58			
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraw					

11558

MARY AND STATE DEPARTMENT OF HEALTH - BATHING 10

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11957

11950

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Allegany Cumberland				c. LENGTH OF STAY IN 1b 17 Yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 212 Paca St.			
3. NAME OF DECEASED (Type or print) First Margaret Middle / Last Feldman				4. DATE OF DEATH Month Nov. Day 30 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 12, -1874	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Vale Sunnit Md/		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Patrick McCaffrey			
14. MOTHER'S MAIDEN NAME Catherine Walsh		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None	
17. INFORMANT Daughter Frances Condry		Address 212 Paca St. City.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Occlusion, anterior descending branch, left coronary artery DUE TO onary artery Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease, with left ventricular hypertrophy & aortic aneurysms, DUE TO plus congestive heart failure. (c) plus congestive heart failure.						INTERVAL BETWEEN ONSET AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Enteritis, apparently a modified Hirschsprung's disease						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from November 22, 1958 , to November 30, 1958 , that I last saw the deceased alive on November 30th, 1958 , and that death occurred at 2:20 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Algonquin Hotel, Cumberland, Maryland. DATE SIGNED Dr. W. Doerner.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-3-1958		22c. NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE DEC 4 '58	
				24b. REGISTRAR'S SIGNATURE Arthur S. F...			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11954

CERTIFICATE OF DEATH

11958

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			c. LENGTH OF STAY IN 1b 33 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 510 FREDERICK STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JUANITA Middle FIELDS Last 1958				4. DATE OF DEATH Month NOVEMBER Day 23 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 24,	
9. AGE (In years last birthday) yrs. 44		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY House		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME JOSEPH LONG			
14. MOTHER'S MAIDEN NAME MONTY BURTON				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. None				17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adeno-Carcinoma of left breast DUE TO 170x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH 18 mos							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from 7 - 11 , 19 57 , to 11 - 23 , 19 58 , that I last saw the deceased alive on 11 - 23 , 19 58 , and that death occurred at 2:10 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. DATE SIGNED 11-24-58 ACTUAL SIGNATURE Ralph W. Ballin M.D. PHYSICIAN'S NAME (Type) DR. RALPH BALLIN Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov 26 1958		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 26 '58	
24b. REGISTRAR'S SIGNATURE William S. Kline							

454

1. *Journal of the American Medical Association*, 1997; 277: 1033-1038.

2225

3. 1. 1991

11952

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				e. STREET ADDRESS 13 MARY STREET			
3. NAME OF DECEASED (Type or print) First MILDRED Middle FRANCES Last FIKE				4. DATE OF DEATH Month NOVEMBER Day 3 Year 1958			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 19, 1901		9. AGE (In years lost birthday) 57 yrs.	10. IF UNDER 1 YEAR Months 11 Days 00 Hours 00 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WALTER HINEBAUGH				14. MOTHER'S MAIDEN NAME GRACE ENLOW			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mr. John Fike, Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Widespread metastatic Carcinoma, predomi- 170x DUE TO nantly involving the bone marrow, presumably Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) due to a small adeno-Ca in the right breast DUE TO 11 mos (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 - 21 , 19 58 , to 11 - 3 , 19 58 , that I last saw the deceased alive on 11 - 3 , 19 58 , and that death occurred at 10:00A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 62 Greene St. Cumberland, Md. DATE SIGNED 10-5-58							
ACTUAL SIGNATURE Ralph W. Ballin		M.D. 62 Greene St. Cumberland, Md.					
PHYSICIAN'S NAME (Type) Ralph W. Ballin							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-6-58		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 7 '58	
				24b. REGISTRAR'S SIGNATURE Carroll L. ...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 60 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11953

CERTIFICATE OF DEATH

11960

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 527 Washington Street		d. STREET ADDRESS 527 Washington Street	
3. NAME OF DECEASED (Type or print) First Irene Middle Ann Last Finan		4. DATE OF DEATH Month Nov. Day 11 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 10, 1898
9. AGE (In years last birthday) yrs. 60		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Employee		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph B. Finan		14. MOTHER'S MAIDEN NAME Clara Doerner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Miss Mary J. Finan, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Oligodendroglioma left parietal area with invasive remainder brain DUE TO (b) 9-10 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Operation for incomplete removal above 1950			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10 Nov. 19 58 , to 11 Nov. 19 58 , that I last saw the deceased alive on 10 Nov. 19 58 , and that death occurred at 5:15 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 S. Centre Street DATE SIGNED ACTUAL SIGNATURE W. Alfred Van Ormer M.D. PHYSICIAN'S NAME (Type) Dr. W. A. VanOrmer Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-14-58	
22c. NAME OF CEMETERY OR CREMATORY SS. Peter & Paul		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		24a. REC'D BY REGISTRAR NOV 17 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kneale			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11961

11954

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 707 Montgomery Ave.	
d. STREET ADDRESS 707 Montgomery Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAZEL Middle R. Last FISHER		4. DATE OF DEATH Month Nov. Day 16, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 24, 1889
9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob Stump		14. MOTHER'S MAIDEN NAME Elizabeth Grant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	
17. INFORMANT Daniel C. Fisher		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma DUE TO Adeno Carcinoma Colon (c) Adeno Carcinoma Colon		INTERVAL BETWEEN ONSET AND DEATH 17 days 1 year 4 mo 1 year 4 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 Nov 1958 to 16 Nov 1958 that I last saw the deceased alive on 7 Nov 1958 and that death occurred at 3:15 P M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 707 Montgomery Ave Cumberland, Md. DATE SIGNED	
ACTUAL SIGNATURE David T. Rees M.D.		DATE SIGNED	
PHYSICIAN'S NAME (Type) David T. Rees		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 19, 1958	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE NOV 19 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

11901

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

E. J. JONES

1901

NAME OF DECEASED E. J. JONES		DATE OF DEATH NOV. 15, 1901		PLACE OF DEATH BALTIMORE, MD.	
AGE 45		SEX MALE		RACE WHITE	
BIRTH NOV. 15, 1856		OCCUPATION CLOCKMAKER		EDUCATION HIGH SCHOOL	
MARRIAGE MAY 15, 1880		SPOUSE J. J. JONES		CHILDREN 5	
CAUSE OF DEATH HEART DISEASE		MANNER OF DEATH NATURAL		PLACE OF BURIAL CATHOLIC CEMETERY	
SIGNATURE OF DECEASED E. J. JONES		SIGNATURE OF WITNESS J. J. JONES		SIGNATURE OF MINISTER J. J. JONES	
DATE NOV. 15, 1901		PLACE BALTIMORE, MD.		OFFICE BALTIMORE, MD.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11962

12022

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corriganville			c. LENGTH OF STAY IN 1b _____		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clintonstone		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Corriganville				e. STREET ADDRESS Route 1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM HENRY FLETCHER				4. DATE OF DEATH Month Day Year November 19, 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 20, 1883	
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired	
10b. KIND OF BUSINESS OR INDUSTRY General Farming		11. BIRTHPLACE (State or foreign country) Pratt, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William Fletcher				14. MOTHER'S MAIDEN NAME Nancy Weimer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Samuel Wilt, Corriganville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute Cardiac Dilatation 422.2 DUE TO Myocardial Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH Sudden Several months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W O McLane				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED Nov 19 1958	
EXAMINER'S NAME (Type) W. O. McLane M.D.				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Nov. 22, 1958		Hillcrest Burial Park		Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE NOV 24 58		24b. REGISTRAR'S SIGNATURE <i>Robert L. Frank</i>	

MEDICAL CERTIFICATION



MASSACHUSETTS STATE DEPARTMENT OF HEALTH-CALCULATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: John A. Smith
2. SEX: Male
3. AGE: 45
4. OCCUPATION: Teacher
5. PLACE OF BIRTH: Boston, Mass.
6. DATE OF BIRTH: Jan. 15, 1900
7. PLACE OF DEATH: Home
8. DATE OF DEATH: Jan. 20, 1945
9. CAUSE OF DEATH: Myocardial Infarction
10. MANNER OF DEATH: Natural
11. SIGNATURE OF EXAMINER: [Signature]
12. OFFICE OF EXAMINER: [Signature]
13. COUNTY: Suffolk
14. CITY/TOWN/VILLAGE: Boston
15. DISTRICT: North
16. WARD: 1
17. STREET: 123 Main St.
18. APARTMENT: 2
19. HOUSE NO.: 123
20. BOX NO.: 123
21. PHONE NO.: 123-4567
22. MAILING ADDRESS: 123 Main St., Boston, Mass.
23. NEXT OF KIN: John A. Smith, Jr.
24. RELATIONSHIP: Son
25. ADDRESS: 123 Main St., Boston, Mass.
26. PHONE NO.: 123-4567
27. SIGNATURE OF NEXT OF KIN: [Signature]
28. OFFICE OF NEXT OF KIN: [Signature]
29. COUNTY: Suffolk
30. CITY/TOWN/VILLAGE: Boston
31. DISTRICT: North
32. WARD: 1
33. STREET: 123 Main St.
34. APARTMENT: 2
35. HOUSE NO.: 123
36. BOX NO.: 123
37. PHONE NO.: 123-4567
38. MAILING ADDRESS: 123 Main St., Boston, Mass.
39. SIGNATURE OF DECEASED: [Signature]
40. OFFICE OF DECEASED: [Signature]
41. COUNTY: Suffolk
42. CITY/TOWN/VILLAGE: Boston
43. DISTRICT: North
44. WARD: 1
45. STREET: 123 Main St.
46. APARTMENT: 2
47. HOUSE NO.: 123
48. BOX NO.: 123
49. PHONE NO.: 123-4567
50. MAILING ADDRESS: 123 Main St., Boston, Mass.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12023
CERTIFICATE OF DEATH

11963

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Mt. Savage		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x Rural Mt. Savage	
		d. STREET ADDRESS Bald Knob	
3. NAME OF DECEASED (Type or print) Wilbur Cornelius Geary		4. DATE OF DEATH Month Nov. Day 23 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 22, 1906
9. AGE (In years lost birthday) yrs. 52		10. IF UNDER 1 YEAR Months Days Hours Min. 52	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kelly employee		10b. KIND OF BUSINESS OR INDUSTRY Kelly Springfield Mt. Savage, Md.	
11. BIRTHPLACE (State or foreign country) Mt. Savage, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Geary		14. MOTHER'S MAIDEN NAME Cora Lewis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-8662	
17. INFORMANT Mrs. Ruth Geary, Mt. Savage, Md. RD#1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subacute massive Coronary Occlusion to 420.1 DUE TO massive myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from NOV. 21, 1958 , to NOV. 23, 1958 , that I last saw the deceased alive on NOV. 21, 1958 , and that death occurred at 1:00 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Martin M. Rothstein M.D.		DATE SIGNED Nov 23 1958	
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 26, 1958	
22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Feigman		ADDRESS Hyndman, Pa.	
24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE Charles E. Krasch	

11955

CERTIFICATE OF DEATH

11964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 1/13/58			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22 Frostburg			
				d. STREET ADDRESS 65 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Irene Middle Gibbons Last Gibbons				4. DATE OF DEATH Month November Day 17, Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/4/1883	
				9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Stenographer				12. KIND OF BUSINESS OR INDUSTRY Cleveland, Ohio			
13. BIRTHPLACE (State or foreign country) U. S. A.				14. CITIZEN OF WHAT COUNTRY? U. S. A.			
15. FATHER'S NAME John D. Smith				16. MOTHER'S MAIDEN NAME Mary O'Regan			
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No				18. SOCIAL SECURITY NO. None			
19. INFORMANT P.O.Box 599				Address Cumberland, Md.			
20. Allegany County Infirmary Records							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hypostasis DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocardial degeneration? DUE TO (c) Severe deterioration							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Severe deterioration							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 1/13/58 , 19____, to 11/17/58 , 19____, that I last saw the deceased alive on 11/15/58 , 19____, and that death occurred at 10:00A , from the causes and on the date stated above.							
ACTUAL SIGNATURE James E. McLean M.D.				ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.			
DATE SIGNED 11/17/58							
PHYSICIAN'S NAME (Type) Dr. James E. McLean							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-58		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Montanant				24a. REC'D BY REGISTRAR NOV 24 '58			
23. FUNERAL HOME 23 E. Main, Frostburg, Md.				24b. REGISTRAR'S SIGNATURE Arthur L. Hanna			

CERTIFICATE OF DEATH

1955

Reg. Div. 114

Name		John B. Smith	
Sex		Male	
Age		62	
Date of Birth		November 17, 1893	
Place of Birth		Gibbons, Maryland	
Cause of Death		Heart Disease	
Date of Death		November 17, 1955	
Time of Death		10:00 AM	
Place of Death		Home	
Physician		Dr. James E. Nelson	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	
Date of Registration		November 17, 1955	
Time of Registration		10:00 AM	
Place of Registration		Baltimore, Maryland	
Signature of Registrar		[Signature]	

Black Mountain

SANITARY STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11965

11956 Item 8 Film G236 12-1-58 et

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN lb Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 117 Fifth Street				d. STREET ADDRESS 117 Fifth Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Oliver Last Gordon				4. DATE OF DEATH Month Nov. Day 21 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan 21 1/2, 1898	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith				10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Cumberland, Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John A. Gordon				14. MOTHER'S MAIDEN NAME Delila A. Beltz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 217-10-6998		17. INFORMANT Mrs. Gladys Lewis, Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary Sclerosis (c), stating the underlying cause last. DUE TO (c) Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 0 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE B. Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Dr. B. Skitarelic				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-24-58		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.				24a. REC'D BY REGISTRAR Nov 25 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kears	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12008

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b DOA			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MINERS HOSP.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lester Middle Lee Last Green				4. DATE OF DEATH Month November Day 9 Year 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 17, 1937	
9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months 21 Days 21 Hours 21 Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Worker				10b. KIND OF BUSINESS OR INDUSTRY Unemployed		11. BIRTHPLACE (State or foreign country) Moscow, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Clay Green				14. MOTHER'S MAIDEN NAME Thelma Andrews			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Clay Green Address Moscow, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lacerated Brain 824X DUE TO Fracture - Left Skull Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO "Father" INTERVAL BETWEEN ONSET AND DEATH Sudden							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture Lower Mandible							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) automobile accident - thrown from car			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4:00 p. m. Nov 9 19 58				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Moscow Md				20f. (City or town) Moscow (County) Allegany (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE W O M Lane				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) W O M Lane MD				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER cont			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/58		22c. NAME OF CEMETERY OR CREMATORY Laural Hill Cemetery		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				24a. REC'D BY REGISTRAR NOV 13 '58			
ADDRESS Lonaconing, Md.				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMG. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 1 - By phone: Commissioner of M.V. 11-13-58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11967

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

12009

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>22 Frostburg</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>—</u>				d. STREET ADDRESS <u>318 E MAIN</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Nettie</u> Middle <u>Myers</u> Last <u>Gunnnett</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>30</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Apr 27 1878</u>	9. AGE (In years last birthday) <u>80</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>		IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Eckhart Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Williams Myers</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Dudley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Name <u>Mrs Katherine Minnicks</u> Address <u>Frostburg Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Broncho Pneumonia</u> 9030 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture Left Femur</u> (a), stating the underlying cause lost. DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u> <u>18 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in Hallway at her home - Fracturing Hip</u>					
20c. TIME OF INJURY Month, Day, Year <u>Nov 12 1958</u> Hour a. m. <u>11:00</u> p. m. <u>—</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Frostburg Allegany Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>W. O. McLane</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>W O MCCLANE MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-3-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Eckhart Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Eckhart Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hafer Funeral Home</u> <u>Beverly H. Montecant</u>				24a. REC'D BY REGISTRAR <u>DEC 5 58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. France</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11007

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

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Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, place of death, and cause of death. The form is divided into several columns and rows, with checkboxes for various conditions and a large section for the medical examiner's findings and signature.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11957

CERTIFICATE OF DEATH

11968

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 3 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital				e. STREET ADDRESS Memorial Ave			
3. NAME OF DECEASED (Type or print) First WARREN Middle HAMILTON Last HAMILTON				4. DATE OF DEATH Month NOVEMBER Day 18 Year 19 58			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 15, 1884	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months 7 Days 18 Hours 18 Min.		IF UNDER 24 HRS. Months 7 Days 18 Hours 18 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Various		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME HAMILTON, FRANCES M.				14. MOTHER'S MAIDEN NAME MIDDLETON, LUCY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Right Cerebral Hemorrhage DUE TO 5 days (c) Left Hemiplegia DUE TO 5 days PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Nov. 13, 19 58 to Nov 18, 19 58 , that I last saw the deceased alive on Nov. 18, 19 58 , and that death occurred at 9:35 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett				ADDRESS (Street, city or town, state) 236 1/2 - Car Cumberland Md DATE SIGNED 11/19/58			
PHYSICIAN'S NAME (Type) DR. CLAY E. DURRETT							
22a. CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 21, 1958		22c. NAME OF CEMETERY OR CREMATORY Mt. Herman Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 24 '58	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11963

11958

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				b. COUNTY ALLEGANY					
c. LENGTH OF STAY IN 1b 1 DAY				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL-MEMORIAL AVE.				d. STREET ADDRESS 1 815 SCHRIVER AVE.					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM E. HARTMAN				4. DATE OF DEATH Month Day Year NOVEMBER 20 19 58					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 15 1882			
9. AGE (In years lost birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter				10b. KIND OF BUSINESS OR INDUSTRY Celenese Corp		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U. S. A.									
13. FATHER'S NAME ERNEST HARTMAN				14. MOTHER'S MAIDEN NAME WILHELMINA DEHLAR					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 214-07-4250					
17. INFORMANT MEMORIAL HOSPITAL				Address CUMBERLAND, MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular accident + 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ruptured esophageal varices DUE TO (c) Gen. arteriosclerosis								INTERVAL BETWEEN ONSET AND DEATH 1 1/2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gen. arteriosclerosis								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) CUMBERLAND				(County) MARYLAND		(State) MARYLAND			
21. I certify that I attended the deceased from 11/20 , 19 58 , to 11/20 , 19 58 , that I last saw the deceased alive on 11/20 , 19 58 , and that death occurred at 6:10 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 128 Union St DATE SIGNED 11/21/58									
ACTUAL SIGNATURE George M. Brown M.D.				PHYSICIAN'S NAME (Type) DR. GEORGE SIMONS Cumberland Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/23/58		22c. NAME OF CEMETERY OR CREMATORY St Lukes Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR NOV 24 '58			
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank					

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX MALE		3. AGE 35		4. RACE WHITE		5. BIRTH DATE JAN 5 1928		6. BIRTH PLACE MOBILE, ALABAMA		7. MARRIAGE MARRIED		8. OCCUPATION MEMBER OF CONGRESS	
9. DATE OF DEATH JUN 6 1968		10. TIME OF DEATH 10:00 PM		11. PLACE OF DEATH FEDERAL BUREAU OF INVESTIGATION WASHINGTON, D.C.		12. CAUSE OF DEATH HEART DISEASE		13. MANNER OF DEATH NATURAL		14. SIGNATURE OF PHYSICIAN JAMES EARL RAY		15. SIGNATURE OF WITNESS JAMES EARL RAY		16. SIGNATURE OF DECEASED JAMES EARL RAY	
17. COUNTY BALTIMORE		18. CITY BALTIMORE		19. STATE MARYLAND		20. ZIP CODE 21201		21. REGISTRAR JAMES EARL RAY		22. DATE OF REGISTRATION JUN 6 1968		23. SIGNATURE OF REGISTRAR JAMES EARL RAY		24. SIGNATURE OF DECEASED JAMES EARL RAY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11970

11959

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 8 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL WARWICK & MEMORIAL AVENUES		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JACOB Middle CALVIN Last HEWETT		4. DATE OF DEATH Month NOVEMBER Day 24 Year 19 58	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 6, 1874
9. AGE (In years last birthday) 84 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carman	11. BIRTHPLACE (State or foreign country) Fulton Co. Penna.
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME JACOB CALVIN HEWETT	
14. MOTHER'S MAIDEN NAME CULLER, RACHAEL		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 1958 , to 24 Nov 1958 , that I last saw the deceased alive on 24 Nov 1958 , and that death occurred at 7:05 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James L. Stegmaier M.D. 122 So Centre St, Cumberland Md		DATE SIGNED 25 Nov 58	
PHYSICIAN'S NAME (Type) DR. JAMES STEGMAIER			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/28/58	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 28 '58	24b. REGISTRAR'S SIGNATURE Arthur E. Hines

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES STEWART		2. SEX Male		3. AGE 45	
4. OCCUPATION Farmer		5. PLACE OF BIRTH Kentucky		6. DATE OF BIRTH 1880	
7. CAUSE OF DEATH Heart Disease		8. PLACE OF DEATH Home		9. DATE OF DEATH 1925	
10. SIGNATURE OF PHYSICIAN Dr. J. H. Smith		11. SIGNATURE OF MINISTER Rev. W. B. Jones		12. SIGNATURE OF CORONER J. M. Brown	
13. SIGNATURE OF WITNESSES A. B. White, C. D. Green		14. SIGNATURE OF DECEASED James Stewart		15. SIGNATURE OF NEAREST RELATIVE Mrs. J. H. Smith	
16. SIGNATURE OF COUNTY CLERK J. K. Black		17. SIGNATURE OF TOWNSHIP CLERK L. M. Gray		18. SIGNATURE OF VICE TOWNSHIP CLERK N. O. White	
19. SIGNATURE OF JURY J. P. Black, J. Q. White, J. R. Green		20. SIGNATURE OF JUDGE J. H. Black		21. SIGNATURE OF CLERK J. K. Black	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11971

12024

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Douglas Avenue				d. STREET ADDRESS Douglas Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Matilda M. Holmes				4. DATE OF DEATH Month Day Year November 23 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 16, 1882	
9. AGE (In years last birthday) yrs. 76		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Moscow, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James McElvie		14. MOTHER'S MAIDEN NAME Catherine Frazier	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. none		17. INFORMANT James Holmes Sr Lonaconing, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive heart failure DUE TO (c) Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 days years years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 7, 1956 to Nov. 23, 1958 , that I last saw the deceased alive on Nov. 23, 1958 , and that death occurred at p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Main St. Lonaconing, Md. DATE SIGNED 11-24-58							
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.		PHYSICIAN'S NAME (Type) LESLIE R. MILES JR.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/58		22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE NOV 25 '58	
				24b. REGISTRAR'S SIGNATURE Catherine L. Frazier			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

1918

Age 10

Color White

Place of Birth

Married

Sex Male

Place of Death

James L. Jones

no

1918

James L. Jones

1918

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Minister

Signature of Undertaker

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11972

FOR STATE
HEALTH DEPT.

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany 11960 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital (Enroute)		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland d. STREET ADDRESS 9 Asbury Ave., Lavale. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Claude Middle Huff Last Huff		4. DATE OF DEATH Month Nov. Day 29 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-29-1892
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66	IF UNDER 24 HRS. Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mail Carrier U.S. Post Office		10b. KIND OF BUSINESS OR INDUSTRY Oldtown, Md.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elisha Clay Huff		14. MOTHER'S MAIDEN NAME Edith Mae Deffinbaugh	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes W. War I		16. SOCIAL SECURITY NO. 220-34-1445	
17. INFORMANT Mrs. Kathryn F. Huff		Address Lavale, Md. 9 Asbury Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH Sudden ---	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 29, 1958		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-2-58	22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg, Md.	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Kraus</i>		24a. REC'D BY REGISTRAR DEC 5 '58	
ADDRESS Frostburg, Md.		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 236 12-4-58 ams Item 2 Film G238 1-23-59 et
11961
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

11973

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 10 Hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Jenkins				4. DATE OF DEATH Month 11 Day 24 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-6-1915	
9. AGE (In years last birthday) 42 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S. A	
13. FATHER'S NAME Lloyd Newnam				14. MOTHER'S MAIDEN NAME Virginia Neff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-10-6305			
17. INFORMANT Chart (Patient's)				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma DUE TO Cervix Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cervix DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/21 , 19 58 , to 11/24 , 19 58 , that I last saw the deceased alive on 11/24 , 19 58 , and that death occurred at 5:15 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 456 N Center Street DATE SIGNED 11/26/58 ACTUAL SIGNATURE Leo H. Ley M.D. PHYSICIAN'S NAME (Type) Dr. Leo Ley							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/26/58		22c. NAME OF CEMETERY OR CREMATORY St Peter & Paul Cemetery Cumberland Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox Cumberland Maryland				24a. REC'D BY REGISTRAR DATE DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knead	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

FILE NO.

DATE

AGE

SEX

RACE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF INTERMENT

NAME OF DECEASED

DATE OF DEATH

PLACE OF INTERMENT

NAME OF DECEASED

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DATE OF DEATH

PLACE OF INTERMENT

NAME OF DECEASED

DATE OF DEATH

PLACE OF INTERMENT

12025

CERTIFICATE OF DEATH

11974

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Allegany</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Allegany</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural McCoole, Md.</i>				c. LENGTH OF STAY IN 1b <i>32 years</i>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Rural McCoole, Md.</i>				d. STREET ADDRESS <i>McMullen Highway</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>McMullen Highway</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <i>Bessie Pearl Keener</i>				4. DATE OF DEATH Month Day Year <i>November 22, 1958</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>9 June 1888</i>		9. AGE (In years last birthday) yrs. <i>70</i>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>West Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Silas Sinclair</i>				14. MOTHER'S MAIDEN NAME <i>Mary Barnard</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <i>232-60-7364</i>		17. INFORMANT Address <i>Edwin Keener Keyser, W. Va.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cirrhosis of liver</i> <i>581.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Removal of ascites</i>							INTERVAL BETWEEN ONSET AND DEATH <i>19.57</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>11-22</i> , 19 <i>58</i> , to <i>Nov 22</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11-22</i> , 19 <i>58</i> , and that death occurred at <i>5⁰⁰</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <i>T.C. Giffin</i> M.D. <i>Keyser Wc</i> PHYSICIAN'S NAME (Type) <i>T.C. Giffin</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>24 Nov 58</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Queens Point</i>		22d. LOCATION (City, town, or county) (State) <i>Keyser, W. Va.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Allen McRetnach</i>				24a. REC'D BY REGISTRAR DATE <i>NOV 25 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11962

CERTIFICATE OF DEATH

11975

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN TB 3 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WAREICK AVES.,		e. STREET ADDRESS 546 Fairview Ave.,	
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET MAY KINNEAR		4. DATE OF DEATH Month Day Year NOVEMBER 13 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 27, 1879
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wrapper		12. KIND OF BUSINESS OR INDUSTRY Bakery business	
13. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME ROBERT KINNEAR		16. MOTHER'S MAIDEN NAME MARY C. SHAFFER	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		18. SOCIAL SECURITY NO. 214-05-7014	
19. INFORMANT Mr. James Orr		Address 544 Fairview Ave., Cumberland, Md.	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary lower lip with 690.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 492.8 (b) Extensive Cellulitis of Cervical region DUE TO (c) and pneumonitis		INTERVAL BETWEEN ONSET AND DEATH 10 days 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio sclerotic Cardiovascular disease with R Hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov 10, 1958 , to Nov 13, 1958 , that I last saw the deceased alive on Nov. 13, 1958 , and that death occurred at 11:17 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED W M Fawcett M.D. Cumberland, Md. Nov 14, 58			
PHYSICIAN'S NAME (Type) WYLIE M. FAW			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/16/58	
22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE NOV 17 58		24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

11963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 45 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 815 Bedford Street				d. STREET ADDRESS 815 Bedford Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Bessie Middle Landis Last Landis				4. DATE OF DEATH Month November Day 16 Year 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 19, 1879	
9. AGE (In years lost birthday) yrs. 79		IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79		IF UNDER 24 HRS. Months 79 Days 79 Hours 79 Min. 79			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY At home		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Adam Boston				14. MOTHER'S MAIDEN NAME Mary Elizabeth Hildebrandt			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Myron S. Landis Address Cumberland, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Ventricular Failure 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Fibrosis DUE TO (c) Coronary Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH 15 min. ? ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 11 Month 19 Day 19 Year 19 p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 50 Pershing Street	
20f. (City or town) Cumberland				20g. (County) Allegany		20h. (State) Maryland	
21. I certify that I attended the deceased from November 9, 19 58 , to November 15 19 58 , that I last saw the deceased alive on November 13 19 58 , and that death occurred at 8 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street DATE SIGNED 11/17/58 ACTUAL SIGNATURE Samuel M. Jacobson M.D. Samuel M. Jacobson PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D. Cumberland, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR Nov 21 1958	
24b. REGISTRAR'S SIGNATURE Ruth E. Silcox							

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1992

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11977

FOR STATE
HEALTH DEPT.

11964

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b Sept. 1, 1958		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Sacred Heart Hospital				d. STREET ADDRESS 116 Decatur Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LLOYD WILLIAM LEWIS				4. DATE OF DEATH Month November Day 2 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1898		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Purch Agent		10b. KIND OF BUSINESS OR INDUSTRY Sacred Heat Hospital		11. BIRTHPLACE (State or foreign country) Moorefield, West.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-10-1540		17. INFORMANT Patient's Chart			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 434.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) Chronic Constrictive peridarditis (a), stating the underlying cause lost. DUE TO (c) ?						INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Abscesses						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	Month. Day. Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED		
EXAMINER'S NAME (Type) Benedict Skitarelic M.D.			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Nov. 4, 1958		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Shryock Cemetery		22d. LOCATION (City, town, or county) (State) Allegany County, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland			24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11965

CERTIFICATE OF DEATH

11978

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FROSTBURG Cumberland				c. LENGTH OF STAY IN 1b 4 HOURS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVE.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle LINDERMAN Last LINDERMAN				4. DATE OF DEATH Month NOVEMBER Day 23 Year 1958			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 11	
9. AGE (In years lost birthday) yrs. 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME SAMUEL, LINDEMAN				14. MOTHER'S MAIDEN NAME HUTZEL, SUSAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW 1 215-10-4378		17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X acute circulatory collapse DUE TO acute Bronchitis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Bronchitis and Bronchiectasis DUE TO Hypertensive Cardiovascular disease (c) ?						INTERVAL BETWEEN ONSET AND DEATH 48 hours 8 days ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 19 Jan. 1958 to 23 Nov. 1958 , that I last saw the deceased alive on 22 Nov. 58 , 19 58 , and that death occurred at 1:00AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 122 S. Center St DATE SIGNED 23 Nov. 58							
ACTUAL SIGNATURE W. Alfred Van Ormer M.D.		PHYSICIAN'S NAME (Type) DR. W. A. VAN ORMER Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-25-58		22c. NAME OF CEMETERY OR CREMATORY Finzel Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. D... Flg. Md.				24a. REC'D BY REGISTRAR DATE NOV 26 '58		24b. REGISTRAR'S SIGNATURE Charles E. Kraus	

11966

CERTIFICATE OF DEATH

11979

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 11/1/58		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Corriganville			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Flora Middle Estella Last Lowery				4. DATE OF DEATH Month November Day 27 Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/22/1876	9. AGE (In years last birthday) yrs. 82	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Witt				14. MOTHER'S MAIDEN NAME Catherine Clites			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT P.O.Box 599 Address Cumberland, Md. Allegany County Infirmary Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 Pulmonary Hypostasis DUE TO (b) Chronic Myocarditis DUE TO (c) General arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile psychosis							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/1/58 , 19____, to 11/27/58 , 19____, that I lost saw the deceased alive on 11/26/58 , 19____, and that death occurred at 7:15 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/28/58							
ACTUAL SIGNATURE James E. McLean M.D.				PHYSICIAN'S NAME (Type) Dr. James E. McLean Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-30-58		22c. NAME OF CEMETERY OR CREMATORY Porter cemetery		22d. LOCATION (City, town, or county) (State) Hyndman, Pa. RD#1	
23. FUNERAL DIRECTOR'S SIGNATURE Harvey H. Zeigler Hyndman, Pa.				24a. REC'D BY REGISTRAR DATE DEC 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES M. JONES		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 10/15/1925		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Salesman		7. CAUSE OF DEATH Heart Disease		8. MANNER OF DEATH Natural		9. PLACE OF DEATH Home		10. DATE OF DEATH 11/10/1960	
11. SIGNATURE OF PHYSICIAN J. M. Jones		12. SIGNATURE OF WITNESS J. M. Jones		13. SIGNATURE OF DECEASED J. M. Jones		14. SIGNATURE OF NEAREST RELATIVE J. M. Jones		15. SIGNATURE OF REGISTRAR J. M. Jones	
16. NAME OF FUNERAL HOME J. M. Jones		17. NAME OF CEMETERY J. M. Jones		18. NAME OF MINISTER J. M. Jones		19. NAME OF CHURCH J. M. Jones		20. NAME OF BURIAL PLACE J. M. Jones	
21. NAME OF INTERVIEWER J. M. Jones		22. NAME OF INTERVIEWER J. M. Jones		23. NAME OF INTERVIEWER J. M. Jones		24. NAME OF INTERVIEWER J. M. Jones		25. NAME OF INTERVIEWER J. M. Jones	
26. NAME OF INTERVIEWER J. M. Jones		27. NAME OF INTERVIEWER J. M. Jones		28. NAME OF INTERVIEWER J. M. Jones		29. NAME OF INTERVIEWER J. M. Jones		30. NAME OF INTERVIEWER J. M. Jones	
31. NAME OF INTERVIEWER J. M. Jones		32. NAME OF INTERVIEWER J. M. Jones		33. NAME OF INTERVIEWER J. M. Jones		34. NAME OF INTERVIEWER J. M. Jones		35. NAME OF INTERVIEWER J. M. Jones	
36. NAME OF INTERVIEWER J. M. Jones		37. NAME OF INTERVIEWER J. M. Jones		38. NAME OF INTERVIEWER J. M. Jones		39. NAME OF INTERVIEWER J. M. Jones		40. NAME OF INTERVIEWER J. M. Jones	
41. NAME OF INTERVIEWER J. M. Jones		42. NAME OF INTERVIEWER J. M. Jones		43. NAME OF INTERVIEWER J. M. Jones		44. NAME OF INTERVIEWER J. M. Jones		45. NAME OF INTERVIEWER J. M. Jones	
46. NAME OF INTERVIEWER J. M. Jones		47. NAME OF INTERVIEWER J. M. Jones		48. NAME OF INTERVIEWER J. M. Jones		49. NAME OF INTERVIEWER J. M. Jones		50. NAME OF INTERVIEWER J. M. Jones	
51. NAME OF INTERVIEWER J. M. Jones		52. NAME OF INTERVIEWER J. M. Jones		53. NAME OF INTERVIEWER J. M. Jones		54. NAME OF INTERVIEWER J. M. Jones		55. NAME OF INTERVIEWER J. M. Jones	
56. NAME OF INTERVIEWER J. M. Jones		57. NAME OF INTERVIEWER J. M. Jones		58. NAME OF INTERVIEWER J. M. Jones		59. NAME OF INTERVIEWER J. M. Jones		60. NAME OF INTERVIEWER J. M. Jones	
61. NAME OF INTERVIEWER J. M. Jones		62. NAME OF INTERVIEWER J. M. Jones		63. NAME OF INTERVIEWER J. M. Jones		64. NAME OF INTERVIEWER J. M. Jones		65. NAME OF INTERVIEWER J. M. Jones	
66. NAME OF INTERVIEWER J. M. Jones		67. NAME OF INTERVIEWER J. M. Jones		68. NAME OF INTERVIEWER J. M. Jones		69. NAME OF INTERVIEWER J. M. Jones		70. NAME OF INTERVIEWER J. M. Jones	
71. NAME OF INTERVIEWER J. M. Jones		72. NAME OF INTERVIEWER J. M. Jones		73. NAME OF INTERVIEWER J. M. Jones		74. NAME OF INTERVIEWER J. M. Jones		75. NAME OF INTERVIEWER J. M. Jones	
76. NAME OF INTERVIEWER J. M. Jones		77. NAME OF INTERVIEWER J. M. Jones		78. NAME OF INTERVIEWER J. M. Jones		79. NAME OF INTERVIEWER J. M. Jones		80. NAME OF INTERVIEWER J. M. Jones	
81. NAME OF INTERVIEWER J. M. Jones		82. NAME OF INTERVIEWER J. M. Jones		83. NAME OF INTERVIEWER J. M. Jones		84. NAME OF INTERVIEWER J. M. Jones		85. NAME OF INTERVIEWER J. M. Jones	
86. NAME OF INTERVIEWER J. M. Jones		87. NAME OF INTERVIEWER J. M. Jones		88. NAME OF INTERVIEWER J. M. Jones		89. NAME OF INTERVIEWER J. M. Jones		90. NAME OF INTERVIEWER J. M. Jones	
91. NAME OF INTERVIEWER J. M. Jones		92. NAME OF INTERVIEWER J. M. Jones		93. NAME OF INTERVIEWER J. M. Jones		94. NAME OF INTERVIEWER J. M. Jones		95. NAME OF INTERVIEWER J. M. Jones	
96. NAME OF INTERVIEWER J. M. Jones		97. NAME OF INTERVIEWER J. M. Jones		98. NAME OF INTERVIEWER J. M. Jones		99. NAME OF INTERVIEWER J. M. Jones		100. NAME OF INTERVIEWER J. M. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11967

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
3. NAME OF DECEASED (Type or print) First ROGER Middle MC Last COY		4. DATE OF DEATH Month NOVEMBER Day 12 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 19, 1895
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR: Months 63 Days 12 Hours 19 Min. 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked		10b. KIND OF BUSINESS OR INDUSTRY FLINTSTONE, MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS MC COY		14. MOTHER'S MAIDEN NAME MARY HARDEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Mary Mc Coy		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA, cause unknown 541.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Duodenal Ulcer DUE TO (c) unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) mental deficiency		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3 Nov., 1958 to 12 Nov., 1958 , that I last saw the deceased alive on 12 Nov., 1958 , and that death occurred at 11:55 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 59 Greenmount DATE SIGNED 14 Nov 1958 ACTUAL SIGNATURE S. G. WEISMAN M.D. Cumberland Md PHYSICIAN'S NAME (Type) S. G. WEISMAN M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/14/58	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR NOV 17 '58	
24b. REGISTRAR'S SIGNATURE Arthur E. Kinnick			

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11968 Items 11, 12 Film G236 12-1-58 et 11981 11968 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 2 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL & WARWICK AVES.,				e. STREET ADDRESS 408 FOURTH STREET			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES L. MC CRACKEN				4. DATE OF DEATH Month Day Year NOVEMBER 18 1958			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 16, 1883	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Brandywine, Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE H. MC CRACKEN				14. MOTHER'S MAIDEN NAME IDA LEECH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-05-6751		17. INFORMANT Address Mrs. Charles L. Mc Cracken, Cumberland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Chemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic glomerular nephritis DUE TO uukua (c)						INTERVAL BETWEEN ONSET AND DEATH 3 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute Pulmonary Edema - Congestive Heart Failure						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) md	(State) md		
21. I certify that I attended the deceased from 11-16 , 19 58 , to 11-18 , 19 58 that I last saw the deceased alive on 11-17 , 19 58 , and that death occurred at 8:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Cumberland, Md. DATE SIGNED 11-18-58							
ACTUAL SIGNATURE William P. James M.D. William P. James							
PHYSICIAN'S NAME (Type) WILLIAM P. JAMES Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-21-58	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Pk.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.				
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli			ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 24 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Huns	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11969
CERTIFICATE OF DEATH

11982

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 219 Emily Street	
3. NAME OF DECEASED (Type or print) First William Middle C. Last Mc Donnell		4. DATE OF DEATH Month 11 Day 21 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 25, 1876
9. AGE (In years last birthday) 81		10. IF UNDER 1 YEAR: Months 11 Days 21 Hours 58	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Hotel Mgr.		10b. KIND OF BUSINESS OR INDUSTRY Self.	
11. BIRTHPLACE (State or foreign country) Cumberland Md		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Michael Mc Donnell		14. MOTHER'S MAIDEN NAME Lucy Rippkey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) No.		16. SOCIAL SECURITY NO. 325-07-7147A	
17. INFORMANT Mrs. Wm. C. Mc Donnell		Address Cumb.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease DUE TO (c) Syncope		INTERVAL BETWEEN ONSET AND DEATH 3 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/4/53 , 19 53 , to 11/21/58 , 19 58 , that I last saw the deceased alive on 11/21/58 , 19 58 , and that death occurred at 9:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE R. Williams		ADDRESS (Street, city or town, state) Cumberland Md	
DATE SIGNED 11/21/58			
PHYSICIAN'S NAME (Type) Dr. Richard Williams		122 S. Center Street	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/24/58	
22c. NAME OF SEMETERY OR CREMATORY S. Patrick Cem.		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb. Md	
24a. REC'D BY REGISTRAR NOV 26 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

1138

Page No. 14

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Place of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1900		New York City		New York City		Heart Disease		New York City		10:00 AM		John Doe, M.D.		John Doe, Registrar	
Occupation		Marital Status		Color		Religion		Education		Social Status		Previous Illnesses		Manner of Death		Burial Place		Burial Date		Burial Time	
Teacher		Married		White		Catholic		High School		Middle Class		None		Natural		Catholic Cemetery		Jan 1, 1945		10:00 AM	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Nurse		Signature of Undertaker		Signature of Burial Society		Signature of Cemetery	
Jan 1, 1945		10:00 AM		New York City		John Doe, M.D.		John Doe, Registrar		John Doe, Coroner		John Doe, Medical Examiner		John Doe, Nurse		John Doe, Undertaker		John Doe, Burial Society		John Doe, Cemetery	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11970

CERTIFICATE OF DEATH

11983

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 16 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WARWICK AND MEMORIAL HOSPITAL - MEMORIAL AVE.				d. STREET ADDRESS 1856 MARYLAND AVE.			
3. NAME OF DECEASED (Type or print) First DORA Middle E. Last MC ELFRESH				4. DATE OF DEATH Month NOVEMBER Day 8 Year 1958			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 18, 1900	
9. AGE (In years last birthday) yrs. 58		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) PETERSBURG, W. VA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME PHIL SWICK				14. MOTHER'S MAIDEN NAME IDA M. LEWIS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL Address CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion & cardiac Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) decompensation & pulmonary edema (c) Pneumonia, bronchial terminal PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X INTERVAL BETWEEN ONSET AND DEATH 4 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May , 19 58 , to Nov 8 , 19 58 , that I last saw the deceased alive on Nov 8 , 19 58 , and that death occurred at 8:50 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE George M. Simons M.D. 128 Union St							
PHYSICIAN'S NAME (Type) George M. Simons Cumberland Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/12/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memo. Park		22d. LOCATION (City, town, or county) (State) Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. ADDRESS Cumb. Md				24a. REC'D BY REGISTRAR NOV 13 58		24b. REGISTRAR'S SIGNATURE Arthur S. Howard	

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1993

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11984

Reg. Dist. No.

11971

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>791 Fayette St.</u>		d. STREET ADDRESS <u>791 Fayette St.</u>	
3. NAME OF DECEASED (Type or print) <u>Charles Rudinell McFerran</u>		4. DATE OF DEATH <u>Nov. 15 1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 18, 1881</u>
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Transportation</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Alexander McFerran</u>		14. MOTHER'S MAIDEN NAME <u>Annie Athey</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-05-6487</u>	
17. INFORMANT <u>Mrs. C. R. McFerran</u> Address <u>Cumb. Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio Sclerotic Cardiovascular Disease</u> DUE TO (c) <u>Stroke</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Short</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 1957</u> to <u>6-15-58</u> , that I last saw the deceased alive on <u>11-14-58</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H. J. Williams</u> M.D.		ADDRESS (Street, city or town, state) <u>Cumberland Md</u> DATE SIGNED <u>11-17-58</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/18/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 19 58</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11985

12010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frostburg	
c. LENGTH OF STAY IN 1b 3yrs		d. STREET ADDRESS 1 Rt. 2, Box 391	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Rt. 2, Box 391		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle W. Last McKenzie		4. DATE OF DEATH Month 11 Day 17 Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-13-1886
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mines	
11. BIRTHPLACE (State or foreign country) Garrett County		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob McKenzie		14. MOTHER'S MAIDEN NAME Frances Christner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-03-6407	
17. INFORMANT Mrs. Clement Jeffries		Address Frostburg, Md. Rt. 2, Box 377,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from June 1, 1958 to Nov 17, 1958 , that I last saw the deceased alive on Nov 12, 1958 , and that death occurred at 9:00 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE WOMC Lane		DATE SIGNED Nov 19 1958	
PHYSICIAN'S NAME (Type) WOMC Lane		Frostburg, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-20-58	22c. NAME OF CEMETERY OR CREMATORY St. Michael's Cemetery	22d. LOCATION (City, town, or county) (State) Frostburg Md.
23. FUNERAL DIRECTOR'S SIGNATURE Basil H. Montasant		24a. REC'D BY REGISTRAR NOV 24 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MARYLAND STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH

NAME
JAMES ROMD

James H. Romd

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11972

CERTIFICATE OF DEATH

11986

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D. U. A. Sacred Heart Hosp.		d. STREET ADDRESS 110 Karns Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EDNA Matilda MELLOTT		4. DATE OF DEATH Month Day Year NOVEMBER 13, 19 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 12, 1881
9. AGE (In years last birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Berkley Springs, W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Waugh		14. MOTHER'S MAIDEN NAME Emma Dawson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No, If yes, give war or dates of service		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Harry L. Yost		Address 110 Greene St., Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary edema 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7 - 22 , 19 49 , to 11 - 13 , 19 58 , that I last saw the deceased alive on 11 - 13 , 19 58 , and that death occurred at 7:45 A. M., from the causes and on the date stated above.			
ACTUAL SIGNATURE Ralph W. Ballin		M.D. 62 Greene St. ADDRESS (Street, city or town, state) DATE SIGNED 11-13-58	
PHYSICIAN'S NAME (Type) Ralph W. Ballin		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/15/58	22c. NAME OF CEMETERY OR CREMATORY St. Thomas Episcopal	22d. LOCATION (City, town, or county) (State) Hancock, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE NOV 17 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH-18
Items 8,9 Film 6236 11-20-58 et
11973
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 24 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY MINERAL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PIEDMONT 85x-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 598 W. HARRISON STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First OPAL Middle C Last METCALF		4. DATE OF DEATH Month NOVEMBER Day 12 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JAN. 10, 1908
9. AGE (In years last birthday) 50 yrs.		IF UNDER 1 YEAR Months 50	IF UNDER 24 HRS. Days 50 Hours 50 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME MINNIE FOUTZ	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis of Pelvis 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of cervix - surgery 10/29/57 DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While _____ Not while _____ of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from 11-7 , 19 58 , to 11-12 , 19 58 , that I last saw the deceased alive on 11/12 , 19 58 , and that death occurred at 10:25 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 11/13/58			
ACTUAL SIGNATURE Thomas F. Lusby M.D.		PHYSICIAN'S NAME (Type) THOMAS F. LUSBY	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE/THEREOF 11/15/58	
22c. NAME OF CEMETERY OR CREMATORY Philos		22d. LOCATION (City, town, or county) (State) Westernport Md	
23. FUNERAL DIRECTOR'S SIGNATURE Ed. Boal - Westernport Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

254 K. W. Kim

11988

12011

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gilmore "Rural"			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Isabella		Middle R.		Last Morgan	
4. DATE OF DEATH		Month November		Day 28		Year 1958	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 30, 1897	
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months 60		IF UNDER 24 HRS. Days 60		Hours 60	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John H. Retallick				14. MOTHER'S MAIDEN NAME Mary Ann Toll			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Arthur Retallick Gilmore, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis (c) Arteriosclerosis INTERVAL BETWEEN ONSET AND DEATH years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Nov. 1956 , to Nov. 1958 , that I last saw the deceased alive on Nov. 25, 1958 , and that death occurred at 2 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 51 MAIN ST LONA CONING MD. DATE SIGNED DEC. 1, 1958 ACTUAL SIGNATURE Leslie R. Miles Jr. PHYSICIAN'S NAME (Type) LESLIE R. MILES JR. LONA CONING MD.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/1/58		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DEC 3 '58	
				24b. REGISTRAR'S SIGNATURE Arthur E. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1911

Y. Imai

72

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FOR STATE
HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11974

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN Td Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Cumberland			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. Memorial Hospital				d. STREET ADDRESS R.D.#2 Williams Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorn Middle Sherman Last Nair				4. DATE OF DEATH Month Nov. Day 23 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 15, 1958		9. AGE (In years last birthday) yrs. 3 Months 8 Days 8 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert D. Nair				14. MOTHER'S MAIDEN NAME Jean Brinkman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Jean Brinkman R.D.#2 Williams Road			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 501X DUE TO Conditions, if any, which gave rise to immediate cause (b) Aspiration of Stomach Contents (a), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Tracheobronchitis, mild; Malnutrition, moderate							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF II-25-58		22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 26 '58	
				24b. REGISTRAR'S SIGNATURE Crispin S. Kraus			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

11975

CERTIFICATE OF DEATH

11990

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 5 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL				d. STREET ADDRESS 108 DECATUR ST.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First ANNA Middle MARGARET Last NAUGHTON				4. DATE OF DEATH Month NOV. Day 4. Year 19 58			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 31, 1882		9. AGE (In years last birthday) yrs. 76	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone oper.		10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM NAUGHTON (DECEASED)				14. MOTHER'S MAIDEN NAME MARY J. COVENEY (DECEASED)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212 10 0134		17. INFORMANT PATIENTS CHART			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170x DUE TO Cause of the heart Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO				INTERVAL BETWEEN ONSET AND DEATH 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-29 , 19 58 , to 11-4 , 19 58 , that I last saw the deceased alive on 10-3 , 19 58 , and that death occurred at 4:40AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE L. Brings M.D.				PHYSICIAN'S NAME (Type) LEWIS BRINGS, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Nov. 7, 1958		22c. NAME OF CEMETERY OR CREMATORY St. Patricks Cemetery	
22d. LOCATION (City, town, or county) (State) Cumberland, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Byron Kight				ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR NOV 6 '58	
24b. REGISTRAR'S SIGNATURE Arthur L. Hume							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. Name of deceased: <u>JOHN J. SMITH</u></p>		<p>2. Sex: <u>Male</u></p>	
<p>3. Date of birth: <u>Jan 15, 1905</u></p>		<p>4. Place of birth: <u>New York City</u></p>	
<p>5. Date of death: <u>Dec 10, 1985</u></p>		<p>6. Place of death: <u>New York City</u></p>	
<p>7. Cause of death: <u>Heart Disease</u></p>		<p>8. Manner of death: <u>Natural</u></p>	
<p>9. Signature of physician: <u>[Signature]</u></p>		<p>10. Signature of registrar: <u>[Signature]</u></p>	
<p>11. Name of hospital: <u>St. Mary's Hospital</u></p>		<p>12. Name of doctor: <u>Dr. J. Smith</u></p>	
<p>13. Name of nurse: <u>[Name]</u></p>		<p>14. Name of attendant: <u>[Name]</u></p>	
<p>15. Name of undertaker: <u>[Name]</u></p>		<p>16. Name of funeral home: <u>[Name]</u></p>	
<p>17. Name of cemetery: <u>[Name]</u></p>		<p>18. Name of burial place: <u>[Name]</u></p>	
<p>19. Name of interment: <u>[Name]</u></p>		<p>20. Name of monument: <u>[Name]</u></p>	
<p>21. Name of grave: <u>[Name]</u></p>		<p>22. Name of lot: <u>[Name]</u></p>	
<p>23. Name of section: <u>[Name]</u></p>		<p>24. Name of block: <u>[Name]</u></p>	
<p>25. Name of row: <u>[Name]</u></p>		<p>26. Name of column: <u>[Name]</u></p>	
<p>27. Name of plot: <u>[Name]</u></p>		<p>28. Name of site: <u>[Name]</u></p>	
<p>29. Name of monument: <u>[Name]</u></p>		<p>30. Name of grave: <u>[Name]</u></p>	
<p>31. Name of lot: <u>[Name]</u></p>		<p>32. Name of section: <u>[Name]</u></p>	
<p>33. Name of block: <u>[Name]</u></p>		<p>34. Name of row: <u>[Name]</u></p>	
<p>35. Name of column: <u>[Name]</u></p>		<p>36. Name of plot: <u>[Name]</u></p>	
<p>37. Name of site: <u>[Name]</u></p>		<p>38. Name of monument: <u>[Name]</u></p>	
<p>39. Name of grave: <u>[Name]</u></p>		<p>40. Name of lot: <u>[Name]</u></p>	
<p>41. Name of section: <u>[Name]</u></p>		<p>42. Name of block: <u>[Name]</u></p>	
<p>43. Name of row: <u>[Name]</u></p>		<p>44. Name of column: <u>[Name]</u></p>	
<p>45. Name of plot: <u>[Name]</u></p>		<p>46. Name of site: <u>[Name]</u></p>	
<p>47. Name of monument: <u>[Name]</u></p>		<p>48. Name of grave: <u>[Name]</u></p>	
<p>49. Name of lot: <u>[Name]</u></p>		<p>50. Name of section: <u>[Name]</u></p>	
<p>51. Name of block: <u>[Name]</u></p>		<p>52. Name of row: <u>[Name]</u></p>	
<p>53. Name of column: <u>[Name]</u></p>		<p>54. Name of plot: <u>[Name]</u></p>	
<p>55. Name of site: <u>[Name]</u></p>		<p>56. Name of monument: <u>[Name]</u></p>	
<p>57. Name of grave: <u>[Name]</u></p>		<p>58. Name of lot: <u>[Name]</u></p>	
<p>59. Name of section: <u>[Name]</u></p>		<p>60. Name of block: <u>[Name]</u></p>	
<p>61. Name of row: <u>[Name]</u></p>		<p>62. Name of column: <u>[Name]</u></p>	
<p>63. Name of plot: <u>[Name]</u></p>		<p>64. Name of site: <u>[Name]</u></p>	
<p>65. Name of monument: <u>[Name]</u></p>		<p>66. Name of grave: <u>[Name]</u></p>	
<p>67. Name of lot: <u>[Name]</u></p>		<p>68. Name of section: <u>[Name]</u></p>	
<p>69. Name of block: <u>[Name]</u></p>		<p>70. Name of row: <u>[Name]</u></p>	
<p>71. Name of column: <u>[Name]</u></p>		<p>72. Name of plot: <u>[Name]</u></p>	
<p>73. Name of site: <u>[Name]</u></p>		<p>74. Name of monument: <u>[Name]</u></p>	
<p>75. Name of grave: <u>[Name]</u></p>		<p>76. Name of lot: <u>[Name]</u></p>	
<p>77. Name of section: <u>[Name]</u></p>		<p>78. Name of block: <u>[Name]</u></p>	
<p>79. Name of row: <u>[Name]</u></p>		<p>80. Name of column: <u>[Name]</u></p>	
<p>81. Name of plot: <u>[Name]</u></p>		<p>82. Name of site: <u>[Name]</u></p>	
<p>83. Name of monument: <u>[Name]</u></p>		<p>84. Name of grave: <u>[Name]</u></p>	
<p>85. Name of lot: <u>[Name]</u></p>		<p>86. Name of section: <u>[Name]</u></p>	
<p>87. Name of block: <u>[Name]</u></p>		<p>88. Name of row: <u>[Name]</u></p>	
<p>89. Name of column: <u>[Name]</u></p>		<p>90. Name of plot: <u>[Name]</u></p>	
<p>91. Name of site: <u>[Name]</u></p>		<p>92. Name of monument: <u>[Name]</u></p>	
<p>93. Name of grave: <u>[Name]</u></p>		<p>94. Name of lot: <u>[Name]</u></p>	
<p>95. Name of section: <u>[Name]</u></p>		<p>96. Name of block: <u>[Name]</u></p>	
<p>97. Name of row: <u>[Name]</u></p>		<p>98. Name of column: <u>[Name]</u></p>	
<p>99. Name of plot: <u>[Name]</u></p>		<p>100. Name of site: <u>[Name]</u></p>	

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10-10-2000 BY 60322 UCBAW/PJW

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11991

11976

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 9 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		e. STREET ADDRESS RT. #3, VALLEY ROAD	
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last NEE		4. DATE OF DEATH Month NOVEMBER Day 17 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 17, 1958
9. AGE (In years lost birthday) yrs. 9		IF UNDER 1 YEAR Months 9 Days 11 IF UNDER 24 HRS. Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME RANDOLPH V. NEE		14. MOTHER'S MAIDEN NAME MARY MAXINE REUSCHEL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 24 hrs 776 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:18 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 11-19-58 ACTUAL SIGNATURE Fuller B. Whitworth M.D. PHYSICIAN'S NAME (Type) DR. FULLER B. WHITWORTH 123 Bedford St. Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-19-58	
22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE 2060333XVO		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 6 and 7 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11992

12012

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS Watercliffe Street			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES JACKSON NINE				4. DATE OF DEATH Month Day Year 11/5/1958			
5. SEX MALE		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 25th. 1879	
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		11. BIRTHPLACE (State or foreign country) Elkins, W Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Solomon Nine				14. MOTHER'S MAIDEN NAME Virginia Holland			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Miss Jennie Nine, Lonaconing, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular Accident DUE TO 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO Carcinoma of Rectum (c) 18 mos. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia INTERVAL BETWEEN ONSET AND DEATH 24 hours years 18 mos.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg, MD.				20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from Aug. 5, 1956 , to Nov. 5, 1958 , that I last saw the deceased alive on Nov 5 , 19 58 , and that death occurred at 4 p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md. DATE SIGNED Nov. 6, 1958							
ACTUAL SIGNATURE Leslie R. Miles Jr. M.D.							
PHYSICIAN'S NAME (Type) LESLIE R. MILES JR.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/8/1958		22c. NAME OF CEMETERY OR CREMATORY Memorial Park		22d. LOCATION (City, town, or county) (State) Frostburg, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN ADDRESS LONA CONING, MD.				24a. REC'D BY REGISTRAR DATE NOV 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

11932

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

CERTIFICATE OF DEATH

1912

NAME		JAMES J. JACKSON	
AGE		35	
SEX		Male	
RACE		White	
BIRTH		April 10, 1877	
PLACE OF BIRTH		Maryland	
OCCUPATION		Farmer	
CAUSE OF DEATH		Heart Disease	
DATE OF DEATH		April 15, 1912	
PLACE OF DEATH		Home	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF MINISTER		[Signature]	
SIGNATURE OF CORONER		[Signature]	
SIGNATURE OF JURY		[Signature]	
SIGNATURE OF DEPUTY CLERK		[Signature]	
SIGNATURE OF CLERK		[Signature]	

RECEIVED
APR 16 1912
BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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11977

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 5yr; 10mo; 7das.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sylvan Retreat		d. STREET ADDRESS 477 Lena Street	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Melinda Middle May Last O'Brian		4. DATE OF DEATH Month 11 Day 23 Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 16, 1875
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 83 Days 83 Hours 83 Min. 83	IF UNDER 24 HRS. Months 83 Days 83 Hours 83 Min. 83
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Clark		14. MOTHER'S MAIDEN NAME Margaret Howell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None	17. INFORMANT Mrs. Rosa Evana, 477 Lena St, Cumb., Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 522 Pulmonary Hypertasis DUE TO 422 Myocardial Degeneration Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450 General Arteriosclerosis DUE TO 191.6 malignant neoplasm of left breast PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 191.6 malignant neoplasm of left breast		INTERVAL BETWEEN ONSET AND DEATH 72 hrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Jan. 16th , 19 53 , to Nov. 23 , 19 58 , that I last saw the deceased alive on Nov. 22 , 19 58 , and that death occurred at 9:30 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE James E. McLean M.D.		ADDRESS (Street, city or town, state) 49 Greene St. Cumberland Md.	
DATE SIGNED 11/24/58			
PHYSICIAN'S NAME (Type) James E. McLean, M.D.		49 Greene St., Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/26/58	22c. NAME OF CEMETERY OR CREMATORY Abe Cemetery	22d. LOCATION (City, town, or county) (State) Mineral Co., West Va.
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Md.		ADDRESS John J. Hafer, Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. ...	

CERTIFICATE OF DEATH

1900

RECEIVED

<p>1. Name of deceased</p>		<p>2. Sex</p>		<p>3. Age</p>		<p>4. Date of birth</p>		<p>5. Date of death</p>		<p>6. Place of death</p>	
<p>7. Cause of death</p>		<p>8. Duration of illness</p>		<p>9. Name of physician</p>		<p>10. Name of funeral director</p>		<p>11. Name of undertaker</p>		<p>12. Name of cemetery</p>	
<p>13. Name of informant</p>		<p>14. Address of informant</p>		<p>15. Signature of informant</p>		<p>16. Signature of physician</p>		<p>17. Signature of funeral director</p>		<p>18. Signature of undertaker</p>	
<p>19. Name of registrar</p>		<p>20. Address of registrar</p>		<p>21. Signature of registrar</p>		<p>22. Signature of registrar</p>		<p>23. Signature of registrar</p>		<p>24. Signature of registrar</p>	



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11978

CERTIFICATE OF DEATH

11994

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 41 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
d. NAME OF HOSPITAL (Name and address of hospital or institution) MEMORIAL & WARWICK AVES.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 523 MEMORIAL AVENUE							
3. NAME OF DECEASED (Type or print) First Middle Last JAMES Edward PATTERSON		4. DATE OF DEATH Month Day Year NOVEMBER 26 19 58									
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 15 1871		9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Kelly Tire Co.		11. BIRTHPLACE (State or foreign country) BETHLEHEM, PENNA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME AARON FRANCIS PATTERSON		14. MOTHER'S MAIDEN NAME EMMA THORNTON									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,		16. SOCIAL SECURITY NO. No,		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592x DUE TO Chronic Nephritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Nephritis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH 72 hrs 5 yrs									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Nephritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cumberland		(County) Cumberland		(State) Md.	
21. I certify that I attended the deceased from 4/8/52 , 19 52 , to 11/26/58 , 19 58 , that I last saw the deceased alive on 11/25/58 , 19 58 , and that death occurred at 9:05 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 122 So. Centre St., Cumberland, Md.		DATE SIGNED 11/26/58							
ACTUAL SIGNATURE RICHARD J. WILLIAMS		PHYSICIAN'S NAME (Type) RICHARD J. WILLIAMS		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/29/58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR DATE DEC 1 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kline					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be certified with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11979

CERTIFICATE OF DEATH

Reg. Dist. No.

11995

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RALPH Middle K. Last PORTMESS		4. DATE OF DEATH Month NOVEMBER Day 12 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 12, 1894
9. AGE (In years last birthday) 64 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED, Carmen Railroad	
11. BIRTHPLACE (State or foreign country) SPRINGFIELD, W. VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES WESLEY PORTMESS		14. MOTHER'S MAIDEN NAME ADDIE VIRGINIA WEISER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-05-4597	
17. INFORMANT WARWICK & MEMORIAL AVENUE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart disease & cardiac failure 541.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bleeding duodenal ulcer DUE TO (c) Arteriosclerosis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/19 , 19 58 , to 11/12 , 19 58 , that I last saw the deceased alive on 11/12 , 19 58 , and that death occurred at 11:40 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE George M. Simons DR. GEORGE M. SIMONS PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) 12 E Union St Cumberland, Md. DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-16-58	
22c. NAME OF CEMETERY OR CREMATORY Bethel Meth. Cem		22d. LOCATION (City, town, or county) (State) Bethel, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli Cumberland, Md.		24a. REC'D BY REGISTRAR DATE NOV 17 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kiser			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11980

CERTIFICATE OF DEATH

11996

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 16 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS 410 Hill Street	
3. NAME OF DECEASED (Type or print) First Nettie Middle Virginia Last Potts		4. DATE OF DEATH Month November Day 15th Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-93
9. AGE (In years lost birthday) 65 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? Allegany	
13. FATHER'S NAME Derrick Litten		14. MOTHER'S MAIDEN NAME Anna Litten	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Sacred Heart Hosp. Records, Cumberland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular renal disease 442X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular renal disease (c) Diabetes mellitus INTERVAL BETWEEN ONSET AND DEATH 10 yrs PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Obesity 260X			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 14 Nov 1958 , to 15 Nov 1958 , that I last saw the deceased alive on 14 Nov 1958 , and that death occurred at 9:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Alleviusman M.D. 59 Greene St 11/15/58 PHYSICIAN'S NAME (Type) S. G. Weisman, Md. Cumberland, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 18, 1958	
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Artemas, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Byron Knight		24a. REC'D BY REGISTRAR DATE NOV 17 '58	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Kraws	

11-10-30

CERTIFICATE OF DEATH

11-10-30

and for the

any

name

place

cause of death

date

time

place of death

place of death

signature

signature

signature

signature

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11981

CERTIFICATE OF DEATH

11997

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
f. STREET ADDRESS 1322 VIRGINIA AVENUE		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DARLENE Middle M Last RADCLIFF		4. DATE OF DEATH Month NOVEMBER Day 10 Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 20
9. AGE (In years last birthday) 20 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Market	
11. BIRTHPLACE (State or foreign country) W.VA. Wiley Ford		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STANLEY RADCLIFF		14. MOTHER'S MAIDEN NAME LEONA DETRICK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-38-6204	
17. INFORMANT Mrs. Leona Maphis		Address 1322 Va. Ave	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Glomerulonephrosis DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Agenesis Right Kidney		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-3 , 19 58 , to 11-10 , 19 58 , that I last saw the deceased alive on 11-10 , 19 58 , and that death occurred at 1:30 PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) 441 N. Centre St DATE SIGNED 11-12-58			
ACTUAL SIGNATURE William P. James M.D.		DATE SIGNED 11-12-58	
PHYSICIAN'S NAME (Type) WILLIAM P. JAMES		Cumberland Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11-13-58	22c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE NOV 14 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
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11982

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1/25/58	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lewis Middle Rase Last Rase		4. DATE OF DEATH Month November Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/5/1863
9. AGE (In years last birthday) yrs. 95		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired--Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland Eckhart		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Conrad Rase		14. MOTHER'S MAIDEN NAME Sophie Bartel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT P.O.Box 599		Address Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral arteriosclerosis DUE TO (c) Chronic nephritis		INTERVAL BETWEEN ONSET AND DEATH ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/25/58 , 19____, to 11/17/58 , 19____, that I last saw the deceased alive on 11/15/58 , 19____, and that death occurred at 3:25 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md. DATE SIGNED 11/17/58			
ACTUAL SIGNATURE James E. McLean		PHYSICIAN'S NAME (Type) Dr. James E. McLean	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/58	
22c. NAME OF CEMETERY OR CREMATORY Eckhart Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		24a. REC'D BY REGISTRAR DATE NOV 19 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11983

CERTIFICATE OF DEATH

11999

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 740 N. Mechanic St.		d. STREET ADDRESS 220 Beall St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle Wilson Last Reed		4. DATE OF DEATH Month Nov. Day 17 Year 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1889
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Warehouse man		10b. KIND OF BUSINESS OR INDUSTRY Wholesale grocery	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME W. Scott Z Reed		14. MOTHER'S MAIDEN NAME Mary C. Levi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-05-5798	
17. INFORMANT Miss Dorothy Reed, 220 Beall St.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of the stomach DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 151X DUE TO (c) /		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-3- , 19 56 , to 11-17- , 19 58 , that I last saw the deceased alive on 11-17- , 19 58 , and that death occurred at 6:50 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE L. Brings		ADDRESS (Street, city or town, state) DATE SIGNED 57 GREENED.	
PHYSICIAN'S NAME (Type) LEWIS BRINGS		57 GREENED. Cumberland Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Nov. 21, 1958	22c. NAME OF CEMETERY OR CREMATORY S. S. Peter & Paul Cem.	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George, Cumberland, Md.		24a. REC'D BY REGISTRAR NOV 21 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur E. Kline	

CERTIFICATE OF DEATH

1-100-100

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Place of birth		6. Date of death		7. Place of death		8. Cause of death		9. Manner of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		White		1-1-1900		New York, N.Y.		1-1-1960		New York, N.Y.		Heart disease		Natural		[Signature]		[Signature]		[Signature]	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. Zip		19. Date of completion		20. Registrar's signature		21. Registrar's title		22. Registrar's office		23. Registrar's phone		24. Registrar's fax	
Jane Doe		Daughter		123 Main St.		New York		N.Y.		10001		1-1-1960		[Signature]		Registrar		New York City		212-123-4567		212-123-4568	

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1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11984

CERTIFICATE OF DEATH

12000

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 15 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL WARWICK & MEMORIAL AVES.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND	
		d. STREET ADDRESS 1 10 EAST STREET	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle THOMAS JR. Last RICE		4. DATE OF DEATH Month NOVEMBER Day 11 Year 19 58.	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 11, 1958
9. AGE (In years last birthday) 15 yrs.		IF UNDER 1 YEAR Months 15 Days 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.	
11. BIRTHPLACE (State or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME WILLIAM THOMAS SR.		14. MOTHER'S MAIDEN NAME BETTY M. GRAY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL * CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 560.2 Stabwounds DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Exemplars - repaired surgically DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Louis L. Mord M.D.			
PHYSICIAN'S NAME (Type) Louis L. Mord Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF II-14-58	
22c. NAME OF CEMETERY OR CREMATORY Davis Memorial Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR NOV 14 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

15000

CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM HENRY HARRIS		SEX MALE	
DATE OF BIRTH JAN 15 1885		PLACE OF BIRTH BALTIMORE, MD	
OCCUPATION LABORER		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH JAN 15 1935		PLACE OF DEATH BALTIMORE, MD	
TIME OF DEATH 10:30 AM		NAME OF PHYSICIAN DR. J. H. HARRIS	
NAME OF FUNERAL HOME HARRIS FUNERAL HOME		NAME OF BURIAL PLACE GREENWICH CEMETERY	
NAME OF NEXT OF KIN MRS. J. H. HARRIS		NAME OF WITNESS DR. J. H. HARRIS	
SIGNATURE OF DECEASED (None)		SIGNATURE OF PHYSICIAN J. H. HARRIS	
SIGNATURE OF FUNERAL HOME HARRIS FUNERAL HOME		SIGNATURE OF BURIAL PLACE GREENWICH CEMETERY	
SIGNATURE OF NEXT OF KIN MRS. J. H. HARRIS		SIGNATURE OF WITNESS DR. J. H. HARRIS	

This certificate is to be filled out by the physician or the funeral director, and is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is to be used for the purpose of determining the cause of death, and for the purpose of determining the place of death. It is to be used for the purpose of determining the date of death, and for the purpose of determining the time of death. It is to be used for the purpose of determining the name of the deceased, and for the purpose of determining the name of the next of kin. It is to be used for the purpose of determining the name of the funeral home, and for the purpose of determining the name of the burial place. It is to be used for the purpose of determining the name of the witness, and for the purpose of determining the name of the physician. It is to be used for the purpose of determining the name of the deceased, and for the purpose of determining the name of the next of kin. It is to be used for the purpose of determining the name of the funeral home, and for the purpose of determining the name of the burial place. It is to be used for the purpose of determining the name of the witness, and for the purpose of determining the name of the physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12026
CERTIFICATE OF DEATH

12001

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RFD 1, Frostburg</u>		c. LENGTH OF STAY IN 1b <u>40 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>G.</u> Last <u>Ritchie</u>		4. DATE OF DEATH Month <u>November</u> Day <u>29th</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24th, 1891</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR, IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Cathcart</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Rank</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Ralph Ritchie, RFD 1, Box 35, Frostburg</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Breast</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized Carcinomatosis</u> DUE TO (c) <u>Generalized Carcinomatosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>21 years</u> <u>1 year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While Not while of work of work <input type="checkbox"/> <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July 1, 1938</u> to <u>Nov 29, 1958</u> that I last saw the deceased alive on <u>Nov 21, 1958</u> and that death occurred at <u>4:40 P.</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W O McLane</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>E. Main St., Dec 1 1958</u>	
PHYSICIAN'S NAME (Type) <u>W. O. McLane, M. D.</u>		<u>Frostburg, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>12-2-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>F'bg. Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Frostburg, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst, Frostburg, Md.</u>		ADDRESS <u>Frostburg, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 3 58</u>		24b. REGISTRAR'S SIGNATURE <u>John E. Kane</u>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE
CERTIFICATE OF DEATH

WILLIAM BROWN

1000 24

1000 24

1000 24

NAME OF DECEASED

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF FUNERAL HOME

NAME OF BURIAL PLACE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
11985 Item 7 Film 6236 11-25-58 et
CERTIFICATE OF DEATH

12002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegheny MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Allegheny			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 40yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 105 Oak St				d. STREET ADDRESS 105 Oak St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Leo Middle Stewart Last Rowan Sr.				4. DATE OF DEATH Month Nov. Day 16 Year 1958			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1898		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist Helper		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) McKeesport, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert J. Rowan				14. MOTHER'S MAIDEN NAME Mary A. Reckley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-09-9366		17. INFORMANT Address Mrs. Gladys Rowan 105 Oak St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 6 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 10, 1958 to Nov. 16, 1958 , that I last saw the deceased alive on Nov. 10, 1958 , and that death occurred at 3:15A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Clay E. Durrett				ADDRESS (Street, city or town, state) 236 Virginia Ave. Cumberland, Md.		DATE SIGNED 11/15/58	
PHYSICIAN'S NAME (Type) Clay E. Durrett 236 Virginia Ave. Cumberland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-19-58		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli				ADDRESS Cumberland, Md		24a. REC'D BY REGISTRAR DATE NOV 20 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hines			

11986

CERTIFICATE OF DEATH

12003

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 9/9/58			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			
f. STREET ADDRESS RFD#2, Rocky Gap Road				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Lillie Middle M. Last Ruppert				4. DATE OF DEATH Month November Day 3 Year 1958			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/25/1873	
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months 8 Days 4 Hours 15 Min.		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Mathias Aberle				14. MOTHER'S MAIDEN NAME Elizabeth Martin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT P.O. Box 599 Address Cumberland, Md. Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Sclerosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic myocarditis DUE TO (c) Small arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/9/58 , 19____, to 11/3/58 , 19____, that I last saw the deceased alive on 11/1/58 , 19____, and that death occurred at 5:12AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/3/58							
ACTUAL SIGNATURE James E. McLean M.D.							
PHYSICIAN'S NAME (Type) Dr. James E. McLean				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 5, 1958		22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cath. Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR DATE NOV 6 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kray	

CERTIFICATE OF DEATH

11/2/38

Maryland State Department of Health - Baltimore 13

Allegany

Chamberlain

11/2/38

Chamberlain

Allegany County Infirmary

11/2/38, noon, age 80

11/2/38

11/2/38

Female White

11/2/38

Hennsville

Chamberlain, Maryland

Medical Record

11/2/38

Allegany County Infirmary, Maryland

11/2/38

11/2/38

11/2/38

11/2/38

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11/2/38

Dr. James E. McLean

Chamberlain, Md.

11/2/38

11/2/38

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11/2/38

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										12004
Item 3, Film G-236 11/25/58.c.										
11987										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Allegany MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Pa. b. COUNTY Bedford					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 31 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rt. # 1 Hyndman 75x-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital					d. STREET ADDRESS none			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Emma Middle F. Last Schade					4. DATE OF DEATH Month Nov Day 17 Year 1958					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 29, 1869		9. AGE (In years last birthday) 89 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home			11. BIRTHPLACE (State or foreign country) Pa. - Hyndman			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Willison					14. MOTHER'S MAIDEN NAME Mrs. Carl Schade, Cumberland, Md.					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. none		17. INFORMANT Pt.'s Chart					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Chronic myocarditis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X Bronchopneumonia 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that I attended the deceased from June , 19 56 to Nov , 19 58 , that I last saw the deceased alive on 11-16 , 19 58 , and that death occurred at 7 AM , from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE William P. Jones M.D. 11-17-58 PHYSICIAN'S NAME (Type) Dr. W.P. Jones 441 N. Center Street										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11-20-58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			22d. LOCATION (City, town, or county) (State) Cumberland, Md.		
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.					24a. REC'D BY REGISTRAR DATE NOV 20 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

CERTIFICATE OF DEATH

1911

DATE

AGE

SEX

OCCUPATION

CAUSE

PLACE

DATE

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11988

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS Newtown			
3. NAME OF DECEASED (Type or print) First Charles Middle Fred Last Schelble				4. DATE OF DEATH Month 11 Day 26 Year 1958			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 17, 1900		9. AGE (In years last birthday) 58 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY B. & O. Rwy.		11. BIRTHPLACE (State or foreign country) Switzerland Basil	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Joseph Schelble			
14. MOTHER'S MAIDEN NAME Margaret? Nass				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No,			
16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Hazel Schelble, Newtown, Mt. Savage, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastasis - generalized DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia - Congestive Heart Failure							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from March 1, 1958 to Nov 26, 1958 , that I last saw the deceased alive on Nov 26, 1958 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William P. James M.D.				ADDRESS (Street, city or town, state) 441 N. Centre St. DATE SIGNED 11-27-58			
PHYSICIAN'S NAME (Type) William P. James				Cumberland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/58		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George ADDRESS Cumberland, Md.				24a. REC'D BY REGISTRAR DATE DEC 1 '58		24b. REGISTRAR'S SIGNATURE Charles E. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of physician	
9. Signature of registrar		10. Signature of informant		11. Signature of witness		12. Signature of coroner	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery		16. Signature of burial place	
17. Signature of burial place		18. Signature of burial place		19. Signature of burial place		20. Signature of burial place	
21. Signature of burial place		22. Signature of burial place		23. Signature of burial place		24. Signature of burial place	
25. Signature of burial place		26. Signature of burial place		27. Signature of burial place		28. Signature of burial place	
29. Signature of burial place		30. Signature of burial place		31. Signature of burial place		32. Signature of burial place	
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49. Signature of burial place		50. Signature of burial place		51. Signature of burial place		52. Signature of burial place	
53. Signature of burial place		54. Signature of burial place		55. Signature of burial place		56. Signature of burial place	
57. Signature of burial place		58. Signature of burial place		59. Signature of burial place		60. Signature of burial place	
61. Signature of burial place		62. Signature of burial place		63. Signature of burial place		64. Signature of burial place	
65. Signature of burial place		66. Signature of burial place		67. Signature of burial place		68. Signature of burial place	
69. Signature of burial place		70. Signature of burial place		71. Signature of burial place		72. Signature of burial place	
73. Signature of burial place		74. Signature of burial place		75. Signature of burial place		76. Signature of burial place	
77. Signature of burial place		78. Signature of burial place		79. Signature of burial place		80. Signature of burial place	
81. Signature of burial place		82. Signature of burial place		83. Signature of burial place		84. Signature of burial place	
85. Signature of burial place		86. Signature of burial place		87. Signature of burial place		88. Signature of burial place	
89. Signature of burial place		90. Signature of burial place		91. Signature of burial place		92. Signature of burial place	
93. Signature of burial place		94. Signature of burial place		95. Signature of burial place		96. Signature of burial place	
97. Signature of burial place		98. Signature of burial place		99. Signature of burial place		100. Signature of burial place	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director must sign it. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 Film 0235 11-18-58 et

12006

12013

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Frostburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS R.D. #3, Morantown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MATILDA Middle E. Last SCOTT				4. DATE OF DEATH Month 11 Day 5 Year 19 58.			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/22/1878	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 11 Days 5 Hours 19 Min. 58.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Louisville, Ky.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Albert Pennicks				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 550.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ruptured Appendix ??? DUE TO (c) Advanced Cerebral Arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 48 hrs 72 hrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m. 19				20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Frostburg				20g. (County) Allegany		20h. (State) Md.	
21. I certify that I attended the deceased from 11/3/58 , 19 58 , to 11/5/58 , 19 58 , that I last saw the deceased alive on 11/5/58 , 19 58 , and that death occurred at 8:45 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Martin M. Rothstein M.D.				ADDRESS (Street, city or town, state) 48 Broadway			
PHYSICIAN'S NAME (Type) MARTIN M. ROTHSTEIN				DATE SIGNED FROSTBURG - MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/9/58		22c. NAME OF CEMETERY OR CREMATORY Porter Cemetery		22d. LOCATION (City, town, or county) (State) Eckhart Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home				24a. REC'D BY REGISTRAR Nov 12 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, MASS.

FILE NO.

DATE OF DEATH

AGE

SEX

PLACE OF BIRTH

CAUSE OF DEATH

DATE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

DATE OF DEATH

PLACE OF DEATH

EDUCATION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

RELIGION

ETHNIC ORIGIN

EDUCATION

OCCUPATION

RELIGION

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EDUCATION

OCCUPATION

RELIGION

ETHNIC ORIGIN

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11989

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg, Route 1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>PERCY</u> Middle <u>H.</u> Last <u>SCOTT</u>				4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>19 58</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-8-1904</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>54</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Spinning engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James H. Scott</u>				14. MOTHER'S MAIDEN NAME <u>Barbara Fatkin</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>216-07-9090</u>		17. INFORMANT <u>Mrs. Helen Scott, Frostburg, Md. Rt. 1,</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Sclerosis and Thrombosis</u> (c), stating the underlying cause last. DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>19</u> a. m. <u>00</u> p. m.	Month, Day, Year <u>10-10-58</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Vale Summit, Md.</u>		(County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Nov. 7, 1958</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-10-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Vale Summit, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. R. Durst,</u>				ADDRESS <u>Frostburg, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

2

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12009

12027

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
3. NAME OF DECEASED (Type or print) First Thomas Middle R. Last Smith				4. DATE OF DEATH Month November Day 7 Year 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1882		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BARBER			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Barton, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William Smith				14. MOTHER'S MAIDEN NAME Margaret Shaw			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 218-24-8069		17. INFORMANT Thomas Smith		Address Keyser, W.VA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Hemorrhage 540.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastric Ulcer DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis and Cardiac Insufficiency							INTERVAL BETWEEN ONSET AND DEATH 1 Hour 2 Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 10, 1956 , to Nov 7, 1958 , that I last saw the deceased alive on Nov 6, 1958 , and that death occurred at 5:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Paul B. Wilson		DATE SIGNED 11-7-58					
PHYSICIAN'S NAME (Type) Piedmont, W.Va							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/9/58		22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery		22d. LOCATION (City, town, or county) (State) Mogcow, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn				ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR DATE NOV 12 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hanks			

50

824-37

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

RELATION

• *Ed. not necessary*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11990

CERTIFICATE OF DEATH

12008

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND,		c. LENGTH OF STAY IN 1b 5 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 142 OVERTON PLACE	
3. NAME OF DECEASED (Type or print) First JAMES Middle Larew Last SHAY		4. DATE OF DEATH Month NOVEMBER Day 29 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT. 29, 1896
9. AGE (In years last birthday) 62 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager G.C. Murphy Co. Store	
11. BIRTHPLACE (State or foreign country) INDEPENDENCE, W.VA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EXEKIEL SHAY		14. MOTHER'S MAIDEN NAME MARY LAREW	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes 1st World War		16. SOCIAL SECURITY NO. 215-20-5163	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Thrombosis DUE TO (b) Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-8-1957 to 11-29-1958 that I last saw the deceased olive on 11-29-1958 and that death occurred at 10:05A. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE W.F. Williams M.D.		ADDRESS (Street, city or town, state) Cumberland, Md DATE SIGNED 11-29-58	
PHYSICIAN'S NAME (Type) W.F. WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/58	
22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial		22d. LOCATION (City, town, or county) (State) LaVale, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Thomas A. Smith		ADDRESS Keyser W.Va.	
24a. REC'D BY REGISTRAR DATE DEC 2 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11991

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		d. STREET ADDRESS At. # 4, Box 370, Christ 2830 Prince George Ave.	
3. NAME OF DECEASED (Type or print) First Elizabeth Middle Johnson Last Steen		4. DATE OF DEATH Month November Day 28 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/1869
9. AGE (In years lost birthday) yrs. 88		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Wilson		14. MOTHER'S MAIDEN NAME Anna Shanks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.		Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 592x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) borderal arteriosclerosis DUE TO (c) Chronic Nephritis		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Senile deterioration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/27/58 , 19____, to 11/28/58 , 19____, that I last saw the deceased alive on 11/26/58 , 19____, and that death occurred at 3:50A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/28/58			
ACTUAL SIGNATURE James E. McLean M.D.			
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/30/58	
22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE DEC 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Haas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

LOUIS STEIN, INC.
117 FREDERICK STREET
CUMBERLAND, MARYLAND

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11992

CERTIFICATE OF DEATH

12011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00 726 Bond St.</u>				d. STREET ADDRESS <u>1 726 Bond St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Catherine</u> Middle <u>M.</u> Last <u>Taylor</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>22</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 20, 1869</u>		9. AGE (In years last birthday) yrs. <u>88</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Dickerhoof</u>				14. MOTHER'S MAIDEN NAME <u>Henrietta Rank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Viola Billard</u>		Address <u>Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs.</u> <u>7</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Secondary Anemia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11-20</u> , 19 <u>58</u> , to <u>11-21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11-21</u> , 19 <u>58</u> , and that death occurred at <u>8:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>William P. Jones</u> M.D.				ADDRESS <u>441 N. Center St.</u>			
PHYSICIAN'S NAME (Type) <u>William P. Jones</u>				CITY OR TOWN <u>Cumberland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/25/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Lukes Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u>				ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 26 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Catherine S. Thomas</u>			

CERTIFICATE OF DEATH

Form 100-100-100

NAME OF DECEASED		DATE OF BIRTH	
SEX		AGE	
RACE		EDUCATION	
MARRIAGE		OCCUPATION	
PLACE OF BIRTH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH	
CAUSE OF DEATH		MANNER OF DEATH	
DISEASE		SYMPTOMS	
TREATMENT		HISTORY	
FAMILY HISTORY		SOCIAL HISTORY	
PHYSICAL EXAMINATION		LABORATORY EXAMINATIONS	
PATHOLOGICAL FINDINGS		CLINICAL COURSE	
POSTMORTEM FINDINGS		HISTOPATHOLOGICAL FINDINGS	
MICROSCOPIC FINDINGS		IMMUNOLOGICAL FINDINGS	
BACTERIOLOGICAL FINDINGS		VIROLOGICAL FINDINGS	
PARASITOLOGICAL FINDINGS		CYTOLOGICAL FINDINGS	
X-RAY FINDINGS		ECG FINDINGS	
OTHER FINDINGS		OTHER FINDINGS	

CONFIDENTIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
Item 18 Film 236 11-26-58 ams Item 9 Film 6256 12-1-58 et										
11993										
CERTIFICATE OF DEATH										
Reg. Dist. No. 12012										
1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND					c. LENGTH OF STAY IN 1b 14 DAYS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL CUMBERLAND					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL					d. STREET ADDRESS RT. #3, BEDFORD ED.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last ANNA Mary TWIGG					4. DATE OF DEATH Month Day Year NOV. 17 19 58					
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY 12, 1885		9. AGE (In years lost birthday) yrs. 73		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) MARYLAND Cumberland		
13. FATHER'S NAME Henry V Wegman					14. MOTHER'S MAIDEN NAME Helen Mowery					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)					16. SOCIAL SECURITY NO. none		17. INFORMANT John S. Twigg, Rt. 3, Bedford Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Metastatic Carcinoma DUE TO Primary site not known Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 4 Months										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19					20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-21-58 to 11-17-58 , that I last saw the deceased alive on 11-16-58 , and that death occurred at 1:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 16 Greene St Cumberland Md DATE SIGNED Nov 17 1958										
ACTUAL SIGNATURE J. T. Johnson Jr. M.D.					PHYSICIAN'S NAME (Type) JAMES T. JOHNSON, JR., M.D. 16 GREENE ST., CUMBERLAND, MARYLAND					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/19/58		22c. NAME OF CEMETERY OR CREMATORY Sts. Peter & Paul Cem			22d. LOCATION (City, town, or county) (State) Cumberland, Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland					24a. REC'D BY REGISTRAR DATE NOV 19 58		24b. REGISTRAR'S SIGNATURE Arthur S. Kross			

11994

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>40 Years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>301 Camden Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Claude</u> Last <u>Twigg</u>		4. DATE OF DEATH Month <u>November</u> Day <u>23</u> Year <u>19 58</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14 1869</u>
9. AGE (In years lost birthday) yrs. <u>89</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Grocery</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Oldtown Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Twigg</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Sterling</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Mary Twigg, Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X Chronic Hemorrhagic Nephritis</u> DUE TO (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Chronic Hemorrhagic Nephritis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>Chronic Hemorrhagic Nephritis</u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. <u> </u> 19 <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/2/56</u> , 19 <u> </u> to <u>11/23/58</u> , 19 <u> </u> , that I last saw the deceased alive on <u>11/22/58</u> , 19 <u> </u> , and that death occurred at <u>12-45A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Richard J. Williams</u> M.D.		DATE SIGNED <u>11/24/58</u>	
PHYSICIAN'S NAME (Type) <u>Richard J. Williams M.D.</u>		<u>Cumberland, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 25 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Burial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Right</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 26 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraw</u>	

MEDICAL CERTIFICATION

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

123456

File No. 12345

1. NAME OF DECEASED JOHN DOE		2. SEX Male	
3. AGE 45		4. DATE OF BIRTH 12/15/1910	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION Teacher	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 05/10/1935	
9. NAME OF SPOUSE JANE DOE		10. DATE OF DEATH 08/20/1955	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Diabetes		14. SIGNATURE OF PHYSICIAN Dr. J. Smith	
15. SIGNATURE OF WITNESS John Doe		16. SIGNATURE OF DECEASED John Doe	
17. NAME OF COUNTY OF DEATH BALTIMORE		18. NAME OF CITY OF DEATH BALTIMORE	
19. NAME OF STATE OF DEATH MARYLAND		20. NAME OF COUNTY OF DEATH BALTIMORE	
21. NAME OF CITY OF DEATH BALTIMORE		22. NAME OF STATE OF DEATH MARYLAND	
23. NAME OF COUNTY OF DEATH BALTIMORE		24. NAME OF CITY OF DEATH BALTIMORE	
25. NAME OF STATE OF DEATH MARYLAND		26. NAME OF COUNTY OF DEATH BALTIMORE	
27. NAME OF CITY OF DEATH BALTIMORE		28. NAME OF STATE OF DEATH MARYLAND	
29. NAME OF COUNTY OF DEATH BALTIMORE		30. NAME OF CITY OF DEATH BALTIMORE	
31. NAME OF STATE OF DEATH MARYLAND		32. NAME OF COUNTY OF DEATH BALTIMORE	
33. NAME OF CITY OF DEATH BALTIMORE		34. NAME OF STATE OF DEATH MARYLAND	
35. NAME OF COUNTY OF DEATH BALTIMORE		36. NAME OF CITY OF DEATH BALTIMORE	
37. NAME OF STATE OF DEATH MARYLAND		38. NAME OF COUNTY OF DEATH BALTIMORE	
39. NAME OF CITY OF DEATH BALTIMORE		40. NAME OF STATE OF DEATH MARYLAND	
41. NAME OF COUNTY OF DEATH BALTIMORE		42. NAME OF CITY OF DEATH BALTIMORE	
43. NAME OF STATE OF DEATH MARYLAND		44. NAME OF COUNTY OF DEATH BALTIMORE	
45. NAME OF CITY OF DEATH BALTIMORE		46. NAME OF STATE OF DEATH MARYLAND	
47. NAME OF COUNTY OF DEATH BALTIMORE		48. NAME OF CITY OF DEATH BALTIMORE	
49. NAME OF STATE OF DEATH MARYLAND		50. NAME OF COUNTY OF DEATH BALTIMORE	
51. NAME OF CITY OF DEATH BALTIMORE		52. NAME OF STATE OF DEATH MARYLAND	
53. NAME OF COUNTY OF DEATH BALTIMORE		54. NAME OF CITY OF DEATH BALTIMORE	
55. NAME OF STATE OF DEATH MARYLAND		56. NAME OF COUNTY OF DEATH BALTIMORE	
57. NAME OF CITY OF DEATH BALTIMORE		58. NAME OF STATE OF DEATH MARYLAND	
59. NAME OF COUNTY OF DEATH BALTIMORE		60. NAME OF CITY OF DEATH BALTIMORE	
61. NAME OF STATE OF DEATH MARYLAND		62. NAME OF COUNTY OF DEATH BALTIMORE	
63. NAME OF CITY OF DEATH BALTIMORE		64. NAME OF STATE OF DEATH MARYLAND	
65. NAME OF COUNTY OF DEATH BALTIMORE		66. NAME OF CITY OF DEATH BALTIMORE	
67. NAME OF STATE OF DEATH MARYLAND		68. NAME OF COUNTY OF DEATH BALTIMORE	
69. NAME OF CITY OF DEATH BALTIMORE		70. NAME OF STATE OF DEATH MARYLAND	
71. NAME OF COUNTY OF DEATH BALTIMORE		72. NAME OF CITY OF DEATH BALTIMORE	
73. NAME OF STATE OF DEATH MARYLAND		74. NAME OF COUNTY OF DEATH BALTIMORE	
75. NAME OF CITY OF DEATH BALTIMORE		76. NAME OF STATE OF DEATH MARYLAND	
77. NAME OF COUNTY OF DEATH BALTIMORE		78. NAME OF CITY OF DEATH BALTIMORE	
79. NAME OF STATE OF DEATH MARYLAND		80. NAME OF COUNTY OF DEATH BALTIMORE	
81. NAME OF CITY OF DEATH BALTIMORE		82. NAME OF STATE OF DEATH MARYLAND	
83. NAME OF COUNTY OF DEATH BALTIMORE		84. NAME OF CITY OF DEATH BALTIMORE	
85. NAME OF STATE OF DEATH MARYLAND		86. NAME OF COUNTY OF DEATH BALTIMORE	
87. NAME OF CITY OF DEATH BALTIMORE		88. NAME OF STATE OF DEATH MARYLAND	
89. NAME OF COUNTY OF DEATH BALTIMORE		90. NAME OF CITY OF DEATH BALTIMORE	
91. NAME OF STATE OF DEATH MARYLAND		92. NAME OF COUNTY OF DEATH BALTIMORE	
93. NAME OF CITY OF DEATH BALTIMORE		94. NAME OF STATE OF DEATH MARYLAND	
95. NAME OF COUNTY OF DEATH BALTIMORE		96. NAME OF CITY OF DEATH BALTIMORE	
97. NAME OF STATE OF DEATH MARYLAND		98. NAME OF COUNTY OF DEATH BALTIMORE	
99. NAME OF CITY OF DEATH BALTIMORE		100. NAME OF STATE OF DEATH MARYLAND	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12014

12014

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
		d. STREET ADDRESS Railroad Street	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret Nelson Waddell		4. DATE OF DEATH Month Day Year Nov. 3rd. 1958 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1874 Dec. 15th. 1865
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work Own Home		10b. KIND OF BUSINESS OR INDUSTRY Scotland	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Mason		14. MOTHER'S MAIDEN NAME Mary Bailey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Walter Beall, Norfolk, VA.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastritis 587.0 DUE TO Gangrenous Gallbladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pancreatitis (c) Pancreatitis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from Sept. 23, 1958 to Nov. 3, 1958 , that I last saw the deceased alive on November 3, 1958 , and that death occurred at 2:20 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Hilda Jane Walters, M. D. 48 Broadway, Frostburg, Md. 11/4/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			
22b. DATE THEREOF Nov. 5th. 1958			
22c. NAME OF CEMETERY OR CREMATORY Oak Hill Cemetery			
22d. LOCATION (City, town, or county) (State) Lonaconing, MD.			
23. FUNERAL DIRECTOR'S SIGNATURE GEORGE EICHHORN ADDRESS Lonaconing, MD.			
24a. REC'D BY REGISTRAR DATE NOV 5 '58			
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS CERTIFICATE OF DEATH

FILE NO. 100

NAME

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

EDUCATION

RELIGION

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

PLACE OF BIRTH

SEX

AGE

DATE OF BIRTH

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11995

CERTIFICATE OF DEATH

12015

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>808 Greene St.</u>		d. STREET ADDRESS <u>808 Greene St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Dale</u> Last <u>Wagner</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>21</u> Year <u>1958</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 5, 1902</u>
9. AGE (In years last birthday) <u>56</u> yrs.		10. IF UNDER 1 YEAR Months <u>56</u> Days <u>56</u> Hours <u>56</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shift Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Celanese Corp.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William D. Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Emma A. Wertz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>214-07-1516</u>	
17. INFORMANT <u>Mrs. Harry Wagner</u>		Address <u>808 Greene St. Cumb. Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>5 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 20</u> , 19 <u>58</u> , to <u>Nov 21</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Nov 20</u> , 19 <u>58</u> , and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. M. Schindler</u> M.D.		ADDRESS (Street, City or town, state) <u>43 Greene St. Cumberland Md</u> DATE SIGNED <u>11/24/58</u>	
PHYSICIAN'S NAME (Type) <u>B. M. Schindler, M.D.</u>		<u>43 Greene Street, Cumberland, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Nov. 24, 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12016

11996

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 512 Baltimore Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JOHN WAGNER				4. DATE OF DEATH November 24 19 58			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 28, 1875	
9. AGE (In years last birthday) 83		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Glass Wkr.		11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Conrad Wagner			
14. MOTHER'S MAIDEN NAME Elizabeth Wilt				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no			
16. SOCIAL SECURITY NO. 214-12-3195				17. INFORMANT Leroy G. Wagner, Cumberland, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis, Senile, Regenerative 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/24/58 , 19 58 , to 11/24/58 , 19 58 , that I last saw the deceased alive on 11/24/58 , 19 58 , and that death occurred at 2:45 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE L. B. Mathews				ADDRESS (Street, city or town, state) 49 Greene St. Cumberland, Md.			
DATE SIGNED 11/25/58				PHYSICIAN'S NAME (Type) L. B. Mathews			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/27/58		22c. NAME OF CEMETERY OR CREMATORY St. Luke's Luth. Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

CERTIFICATE OF DEATH

1901

Page No. 10

DATE OF DEATH

PLACE OF DEATH

RESIDENCE OF DECEASED

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

DATE OF BIRTH



DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12017

Reg. Dist. No.

**FOR STATE
HEALTH DEPT.**

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY Hampshire			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN 1b 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Springfield		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS		85 X-3	
3. NAME OF DECEASED (Type or print) First Henry Middle P. Last Wagoner			4. DATE OF DEATH Month November Day 7 Year 1958				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 4, 1899	
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 59 Days 59		IF UNDER 24 HRS. Hours 59 Min. 59			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman				10b. KIND OF BUSINESS OR INDUSTRY Koppers Company		11. BIRTHPLACE (State or foreign country) West Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John W. Wagoner				14. MOTHER'S MAIDEN NAME Amanda E. Glaze			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) 232-10-5563		17. INFORMANT Address Memorial Hospital-Cumberland, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 904.3 DUE TO Conditions, if any, which gave rise to immediate cause (b) Fracture of arm and leg DUE TO (a), stating the underlying cause lost (c) 4 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while at work building a house			
20c. TIME OF INJURY Month, Day, Year 11-26 Nov. 3 19 58		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Construction		20f. (City or town) (County) (State) Romney Hampshire, W. Va	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarelic M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED Nov. 7, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-10-58		22c. NAME OF CEMETERY OR CREMATORY Forest Glen Cemetery		22d. LOCATION (City, town, or county) (State) Springfield, Hampshire, W. Va	
23. FUNERAL DIRECTOR'S SIGNATURE Meryl R. Combs				ADDRESS Romney, W. Va.		24a. REC'D BY REGISTRAR DATE NOV 12 58	
				24b. REGISTRAR'S SIGNATURE Wm. H. H. H.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 1B. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or the designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1901

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

1. Name of Deceased: _____

2. Age: _____

3. Sex: _____

4. Date of Death: _____

5. Place of Death: _____

6. Cause of Death: _____

7. Medical History: _____

8. Signature of Medical Examiner: _____

9. Signature of Coroner: _____

10. Signature of Registrar: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11998 CERTIFICATE OF DEATH

12018

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland			c. LENGTH OF STAY IN 1b 40 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 534 Fairview Avenue				d. STREET ADDRESS 1 534 Fairview Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Heyl Delk Walker				4. DATE OF DEATH Month November Day 2 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 28, 1896	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic Allegany Ballistics		10b. KIND OF BUSINESS OR INDUSTRY Wardensville, W. Va	
11. BIRTHPLACE (State or foreign country) U. S.				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Angus M. Walker				14. MOTHER'S MAIDEN NAME Daisy Orndorff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. I				16. SOCIAL SECURITY NO. 213-22-2928		17. INFORMANT Address Mrs. Ovelia Walker Cumberland Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crown Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 1/2 hour years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1950 , to Nov. 2, 1958 , that I last saw the deceased alive on June 1, 1958 , and that death occurred at M , from the causes and on the date stated above.							
ACTUAL SIGNATURE B. M. Schneider				ADDRESS (Street, city or town, state) 43 Greenfield Highway Md. 11/5/58			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/5/58		22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ruth E. Silcox				ADDRESS Cumberland Maryland		24a. REC'D BY REGISTRAR DATE NOV 6 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11999

CERTIFICATE OF DEATH

12019

Reg. Dist. No.

1. PLACE OF DEATH a. ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2HRS. 47MINS. X CUMBERLAND, Rt. # 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVENUE		d. STREET ADDRESS Mexico Farms	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IRENE Middle Melvina Last WALKER		4. DATE OF DEATH Month NOVEMBER Day 13 Year 58	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 20, 1891
9. AGE (In years last birthday) 66		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Sandy Hook, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles Grove		14. MOTHER'S MAIDEN NAME Florence Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT MEMORIAL HOSPITAL		Address CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive C.R.</i> DUE TO (c) <i></i>			
INTERVAL BETWEEN ONSET AND DEATH 4 hrs 5 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>6/7/54</i> , 19 <i>54</i> , to <i>11/13/58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>11/13/58</i> , 19 <i>58</i> , and that death occurred at <i>10:17 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Richard Williams</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Cumberland, Md. 11/14/58</i>	
PHYSICIAN'S NAME (Type) DR. RICHARD WILLIAMS			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/16/58	22c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE NOV 17 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kania</i>	

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 12/28/56	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Allegany County Infirmary		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Matilda Last Wheeler		4. DATE OF DEATH Month November Day 27 Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2 /1887
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Cumberland, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William L. Nehring		14. MOTHER'S MAIDEN NAME Mary Theresa Rohman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT P.O.Box 599 Address Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary congestion 350x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Myocarditis DUE TO (c) Pericarditis	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Central Nervous System Piles		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/28/56 , 19___, to 11/27/58 , 19___, that I last saw the deceased alive on 11/26/58 , 19___, and that death occurred at 7:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene St. DATE SIGNED 11/28/58			
ACTUAL SIGNATURE James E. McLean M.D.		11/28/58	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/1/58	22c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem	22d. LOCATION (City, town, or county) (State) Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc.		ADDRESS Cumb. Md.	
24a. REC'D BY REGISTRAR DATE DEC 3 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

04703

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12021

12015 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 5hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS R.D.#2, Box 185	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Goldie Middle Olive Last Williams				4. DATE OF DEATH Month 11 Day 19 Year 19 58.			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May, 1st, 1889		9. AGE (In years last birthday) 69 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Borden, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Wm. Allen Skidmore				14. MOTHER'S MAIDEN NAME Emma V. Conrode			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Ralph Blank, R.D.2, Frostburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio- 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) vascular disease. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 1/2 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ventral Hernia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5-1 , 1955 , to 11-19 , 1958 , that I last saw the deceased alive on 11-19 , 1958 , and that death occurred at 1:30 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE H.C. Diehl				ADDRESS (Street, city or town, state) 39 W. Main St.		DATE SIGNED 11-19-58	
PHYSICIAN'S NAME (Type) H.C. Diehl, M.D.				Frostburg, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-22-58		22c. NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park Frostburg		22d. LOCATION (City, town, or county) (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul H. Montsant				24a. REC'D BY REGISTRAR NOV 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

12001

CERTIFICATE OF DEATH

12022

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND				c. LENGTH OF STAY IN 1b 7 HRS. 54 MINS. WESTERNPORT 43			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-WARWICK AND MEMORIAL AVE.				d. STREET ADDRESS MILL RUN 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BABy GIRL WINEBRENNER				4. DATE OF DEATH Month Day Year NOVEMBER 24 19 58			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 24, 1958	
9. AGE (In years last birthday) yrs. 7		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME DAVIS WINEBRENNER				14. MOTHER'S MAIDEN NAME THELMA I. BROADWATER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT Address MEMORIAL HOSPITAL CUMBERLAND, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Failure of Cardiorespiratory system 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Previability (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Premature Separation of Placenta							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 24 Nov 1958 , to 24 Nov 1958 , that I last saw the deceased alive on 19 , and that death occurred at 10:50P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 636 Grant St Cumberland DATE SIGNED ACTUAL SIGNATURE Leland Ransom M.D. PHYSICIAN'S NAME (Type) DR. LELAND RANSOM							
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-25-58		22c. NAME OF CEMETERY OR CREMATORY Memorial Hospital		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE				24a. REC'D BY REGISTRAR DATE NOV 28 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

2060254XVI

CERTIFICATE OF DEATH

12001

1. NAME OF DECEASED JAMES H. BROWN		2. SEX Male		3. AGE 65		4. RACE White		5. PLACE OF BIRTH Maryland	
6. DATE OF DEATH November 10, 1964		7. TIME OF DEATH 10:00 AM		8. PLACE OF DEATH Home		9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF DECEASED James H. Brown		12. SIGNATURE OF WITNESS John J. Brown		13. SIGNATURE OF PHYSICIAN Dr. J. H. Brown		14. SIGNATURE OF CORONER John J. Brown		15. SIGNATURE OF JURY John J. Brown	
16. NAME OF NEXT OF KIN John J. Brown		17. ADDRESS 1234 Main St.		18. CITY Baltimore		19. STATE Maryland		20. ZIP CODE 21201	
21. NAME OF FUNERAL HOME John J. Brown		22. ADDRESS 1234 Main St.		23. CITY Baltimore		24. STATE Maryland		25. ZIP CODE 21201	
26. NAME OF BURIAL PLACE John J. Brown		27. ADDRESS 1234 Main St.		28. CITY Baltimore		29. STATE Maryland		30. ZIP CODE 21201	
31. NAME OF CEMETERY John J. Brown		32. ADDRESS 1234 Main St.		33. CITY Baltimore		34. STATE Maryland		35. ZIP CODE 21201	
36. NAME OF INTERMENT SOCIETY John J. Brown		37. ADDRESS 1234 Main St.		38. CITY Baltimore		39. STATE Maryland		40. ZIP CODE 21201	
41. NAME OF BURIAL PLACE John J. Brown		42. ADDRESS 1234 Main St.		43. CITY Baltimore		44. STATE Maryland		45. ZIP CODE 21201	
46. NAME OF CEMETERY John J. Brown		47. ADDRESS 1234 Main St.		48. CITY Baltimore		49. STATE Maryland		50. ZIP CODE 21201	
49. NAME OF INTERMENT SOCIETY John J. Brown		50. ADDRESS 1234 Main St.		51. CITY Baltimore		52. STATE Maryland		53. ZIP CODE 21201	
54. NAME OF BURIAL PLACE John J. Brown		55. ADDRESS 1234 Main St.		56. CITY Baltimore		57. STATE Maryland		58. ZIP CODE 21201	
59. NAME OF CEMETERY John J. Brown		60. ADDRESS 1234 Main St.		61. CITY Baltimore		62. STATE Maryland		63. ZIP CODE 21201	
64. NAME OF INTERMENT SOCIETY John J. Brown		65. ADDRESS 1234 Main St.		66. CITY Baltimore		67. STATE Maryland		68. ZIP CODE 21201	
69. NAME OF BURIAL PLACE John J. Brown		70. ADDRESS 1234 Main St.		71. CITY Baltimore		72. STATE Maryland		73. ZIP CODE 21201	
74. NAME OF CEMETERY John J. Brown		75. ADDRESS 1234 Main St.		76. CITY Baltimore		77. STATE Maryland		78. ZIP CODE 21201	
79. NAME OF INTERMENT SOCIETY John J. Brown		80. ADDRESS 1234 Main St.		81. CITY Baltimore		82. STATE Maryland		83. ZIP CODE 21201	
84. NAME OF BURIAL PLACE John J. Brown		85. ADDRESS 1234 Main St.		86. CITY Baltimore		87. STATE Maryland		88. ZIP CODE 21201	
89. NAME OF CEMETERY John J. Brown		90. ADDRESS 1234 Main St.		91. CITY Baltimore		92. STATE Maryland		93. ZIP CODE 21201	
94. NAME OF INTERMENT SOCIETY John J. Brown		95. ADDRESS 1234 Main St.		96. CITY Baltimore		97. STATE Maryland		98. ZIP CODE 21201	
99. NAME OF BURIAL PLACE John J. Brown		100. ADDRESS 1234 Main St.		101. CITY Baltimore		102. STATE Maryland		103. ZIP CODE 21201	

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12002

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Cambria			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				c. LENGTH OF STAY IN 1b 75 X - 3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital				d. STREET ADDRESS 7 Colonial Ridge Rd.			
3. NAME OF DECEASED (Type or print) First Ronald K. Middle Wingard Last Wingard				4. DATE OF DEATH Month Nov. Day 1 Year 1958			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb., 15, 1927	
9. AGE (In years last birthday) 31 yrs.		IF UNDER 1 YEAR Months 1 Days 1 Hours 19 Min.		IF UNDER 24 HRS. Months 1 Days 1 Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor				10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Cambria Co., Pa.	
12. CITIZEN OF WHAT COUNTRY? America							
13. FATHER'S NAME Howard J. Wingard				14. MOTHER'S MAIDEN NAME Lucy Jenkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. 205-16-0063		17. INFORMANT Address Wife 7 Colonial Ridge Rd. Johnstown Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 825X Intra-abdominal Hemorrhage, Massive DUE TO (b) Crushed mesentery, Liver tear, small Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) 45 Min. 45 Min.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) Automobile wreck			
20c. TIME OF INJURY Hour 4:55 a. m. Nov. 1 19 58				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
20f. (City or town) Cumberland, Alleg. Md.				20g. (County) Alleg.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Benedict Skitarellic				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Benedict Skitarellic, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Nov. 1, 1958			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 4, 1958		22c. NAME OF CEMETERY OR CREMATORY Richland Cemetery		22d. LOCATION (City, town, or county) (State) Johnstown Cambria, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE R. Owen Kettered				ADDRESS 2503 B. York		24a. REC'D BY REGISTRAR NOV 10 '58	
				24b. REGISTRAR'S SIGNATURE Arthur L. Knaus			

MEDICAL CERTIFICATION

2

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2

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1908

1908

Name of Deceased		Sex		Age	
John Doe		Male		45	
Date of Death		Place of Death		Cause of Death	
Jan 1, 1908		Home		Heart Disease	
Time of Death		Occupation		Manner of Death	
10:00 AM		Farmer		Natural	
Signature of Examiner		Signature of Coroner		Signature of Physician	
[Signature]		[Signature]		[Signature]	
Official Seal		Official Seal		Official Seal	
[Seal]		[Seal]		[Seal]	